Bupa Care Homes (GL) Limited

Hillview Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 22 May 2017. This meant the provider, staff and people using the service did not know that we would be carrying out an inspection of the service. We returned on 30 May 2017 to carry out a second day of inspection which was announced.

Throughout June 2017, we received a number of whistleblowing concerns. In response to these, two inspectors carried out a third day of inspection on 3 July 2017 which was unannounced.

Hillview Care Home provides personal and nursing care for up to 53 people who live with a physical impairment, have a mental health condition, a dementia type illness or are living with a learning disability. Hillview Care Home is a large building within its own grounds in a residential area close to local amenities. There are gardens to the front and rear of the service with views of Eston Hills.

At the time of the inspection, there were 49 people using the service who were supported by the registered manager and 73 care staff.

The registered manager has been registered with the Care Quality Commission since May 2017; however they had been in post since 1 August 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not receive person-centred care because the care people were given did not always reflect their needs, wishes and preferences. Staff told us they did not have time to read people's care plans and daily records did not match the needs identified in people's care plans.

People were left in bed throughout each day of inspection. One person asked us if they were allowed to get out of bed. Outside of planned activities there was a lack of stimulation for people. Staff did not spend time sitting with people and talking to them. Staff told us they did not have time.

People's privacy and dignity was not maintained or respected. We observed a nurse walk into a person's room whilst they were receiving personal care without knocking. A used incontinence pad was left next to

one person whilst they were laid in bed. Personal items such as urine bags, incontinence pads and nutritional supplements were on display. One person had been left on the toilet for three hours.

One person did not speak English. There was no information in the care records about how to communicate with this person such as key phrases and very little action was taken to seek alternative means of communication.

Prior to inspection, the Clinical Commissioning Group shared concerns with the management of medicines at the service. The registered manager had taken some action to address these concerns. We identified that the management of medicines needed to be improved. Medicines were signed for before people had been given them. Medicines were crushed without protocols in place. People did not receive their topical creams as prescribed. Nutritional supplements were not stored appropriately.

People at risk of malnutrition were not appropriately supported. Weekly weights were not consistently carried out. Risk assessments and care plans relating to these had not been regularly updated. We identified two people had not been given there breakfast by 11:30 on one of the days of inspection. One of these people was living wit a diagnosis of diabetes.

Staff were not responsive when people's needs changed. We identified delays in responding to people, seeking treatment and obtaining prescribed creams. People at risk of developing pressure sores did not receive appropriate care and treatment. Staff failed to communicate clearly and care records relating to these were inaccurate, incomplete or had not been regularly reviewed.

Records showed people had been bathed at unsafe water temperatures between 20 and 36 degrees Celsius. Bins causing malodours had not been emptied. Incontinence pads and disposable gloves were not readily available for staff.

People's personal information was not protected because we found care records on display on each day of inspection. Some staff shared personal information about people and the service with the public. The provider was taking action to address this.

There were gaps in all care records looked at. Care records were not regularly updated and some contained inaccuracies. Care plans were not always put in place when people moved into the service. This meant staff did not have the information they needed to provide safe care and support to people.

We raised concerns on the first day of inspection and asked for immediate action to be taken, especially in relation to the quality of record keeping. All concerns remained in place on the third day of inspection.

Quality assurance procedures were in place but had not highlighted the same level of concerns during this inspection. There were gaps in audits and information was not always clear. Action plans were put in place, however were not effective because staff did not carry out the tasks identified within them.

A strong and stable team who were supportive of each other was not in place. Staff were not accountable for their actions and did not follow the values of the service. This meant there was a lack of communication and team work.

There were insufficient staff on duty on the first floor of the service. Staff were not appropriately deployed on the ground floor. Call bells went unanswered.

Not all staff had received up to date training in fire safety, pressure area care and moving and handling. Competency checks had not been carried out for staff who lack confidence in using a new hoist. No training in learning disabilities, mental health and Parkinson's disease had been made available for staff despite people with these health conditions using the service.

There were not enough hoists available for people on the first day of inspection. Although an order had been placed, no action had been taken to address the temporary shortfall. We asked the registered manager to address this during inspection. They took action and a further hoist was made available for staff.

The health and safety of the service was regularly monitored. Up to date safety certificates were in place and staff participated in regular planned fire drills.

Personal emergency evacuation plans were in place for each person and detailed important health conditions, medicines and any difficulties with mobility.

Staff training in safeguarding adults was up to date, however staff had not always raised concerns when needed. Where safeguarding alerts had been made, investigations had been carried out and actions put in place to minimise the risk of a reoccurrence.

Care staff had received regular supervision and appraisals, however not all nurses had received their appraisal. The provider already had an action plan in place.

People spoke very positively about the food provided at the service. Regular drinks and snacks were offered to people and each person had a jug of water or diluted juice in their rooms.

Health and social care professionals were involved in people's care. Staff had not always shared information with health professionals in relation to pressure area care. Guidance from these professionals was documented in people's care records. We found some care plans had been updated with this guidance, however others had not.

Staff had followed the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) had been applied for and granted for 10 people. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Dementia friendly signage was on display in some areas of the service. The registered manager told us that this was an area for further development at the service. There were quiet areas available for people and there were flat outside spaces for people.

People spoke positively about the staff who provided care and support to them. We observed positive relationships between people and staff. Staff appeared to know people well. We observed laughing and joking and friendly banter between people and staff.

Care records showed that some people and their relatives had been involved in planning and making decisions about their care. The registered manager told us they regularly met with people and their relatives to discuss the care and support people received. Staff had organised for advocates to be involved in some people's care to ensure their voice was heard.

People spoke positively about planned activities. Details about planned activities were on display and we

observed people enjoying the performance by external singers and a visit from an ex-guide dog.

People knew how to make a complaint it they needed to. Each person spoken to told us they had confidence that the registered manager would take their concerns seriously. At the time of inspection no-one had wanted to raise a complaint. Concerns were raised outside of the days which we visited the service. We shared relevant information with the local authority and registered provider. We also considered these concerns during this inspection process.

Staff were generally supportive of the registered manager, had confidence in them and thought that improvements had been made since they came into post. Most staff told us they enjoyed working at the service and could approach the registered manager.

People told us they had confidence in the registered manager. People and staff told us they were kept up to date with changes at the service and upcoming events at meetings and via newsletters.

The service had links with the local community which included schools and religious organisations. The service held fundraising events such as fairs which the local community were invited to attend.

The registered manager did not fully understood their roles and responsibilities particularly in relation to governance and quality assurance.

We found five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to quality assurance measures, particularly record keeping. You can see what action we told the registered provider to take at the back of the full version of this report.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient staff on the first floor of the service. Staff on the ground floor were not appropriately deployed. There were significant delays in answering call bells and regular checks of people were not carried out.

Staff were not responsive when people's needs changed. Staff did not take appropriate action to reduce the risk of harm to people.

Staff did not follow appropriate procedures for managing people's medicines. There were gaps in all medicines records looked at. People's medicines were crushed without any guidance.

There was a failure to follow procedures for the management and prevention of pressure sores. Improvements were needed to infection prevention and control procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Moving and handling, fire safety and pressure care training were not up to date. Competency checks were not carried out for staff who lacked confidence in using hoists. No training in mental health, learning disabilities and Parkinson's disease had been provided for staff.

People at risk of malnutrition were not regularly monitored by staff. Weekly weights were not regularly carried out, inaccuracies in the records went unnoticed, care plans and food and fluid balance records were not regularly updated.

We alerted staff at 11:30 that two people have not been given their breakfast. One of whom was a type two diabetic.

There was evidence of best interest decision making for people who lacked capacity. Staff understood the requirements of the

Mental Capacity Act 2008.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always maintained. Safeguarding alerts were raised in relation to specific incidents during inspection.

Items such as incontinence pads were on display. Drinks and call bells were not within people's reach. Poor communication meant that one person's dignity was not maintained and a safeguarding alert needed to be made.

People told us they were supported by good staff; felt cared for and enjoyed living at the service.

Care records showed where advocacy services had been involved to ensure people's voices were heard.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The quality of record keeping required improvement. There were gaps in all records reviewed. Two safeguarding alerts for neglect had been partially upheld in respect of record keeping.

People did not receive person centred care. Staff told us they did not have time to read people's care plans and daily records did not reflect people's needs wishes and preferences.

People spoke positively about the quality of planned activities provided at the service. Outside of planned activities there was little meaningful engagement with people and we found people were socially isolated .

People knew how to make a complaint. Records were in place to show the action which had been taken to resolve complaints.

Is the service well-led?

Inadequate

The service was not well-led.

We asked the registered manager to address our immediate concerns with record keeping and with the storage of nutritional supplements on the first day of inspection. However these concerns remained at the end of inspection.

Quality assurance procedures were in place; however they had not identified all of the concerns in this inspection. Information was not shared with staff to allow improvements to be made.

Action plans in place to drive improvement were not productive because staff did not carry out the duties expected of them.

A strong and stable team who were supportive of each other was not in place at the service. The provider was taking action to address this.

Hillview Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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.

Before the inspection we reviewed all of the information we held about the service. The information included notifications that we had received from the service. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted Redcar and Cleveland local authority commissioning team and South Tees Clinical Commissioning Group. We used the information they gave us to help plan the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

One adult social care inspector and two experts by experience carried out this inspection on 22 May 2017. One adult social care inspector returned for a second day of inspection on 30 May 2017. The experts by experience involved in this inspection had experience of working with adults and older people. In June 2017, we received a number of whistleblowing concerns about the service. Two inspectors carried out a third day of inspection on 3 July 2017 in response to growing concerns about the service.

During the inspection we spoke with 22 people and six relatives. We also spoke with the regional manager, registered manager, clinical lead, five nurses, 12 care staff, an activities coordinator, a dining room hostess, a maintenance person and a member of domestic staff.

We reviewed 11 people's care records in detail and the supplementary records (medicine administration records, topical cream records, food and fluid balance records, positional change records and hydration

thickening protocol records) of a further five people. We reviewed five staff recruitment and induction records, the training summary records for all staff and six staff supervision and appraisal records as well as records relating to the management of the service.

We looked around the service and went into some people's bedrooms (with their permission) and visited the communal areas. We carried out observations of practice and conducted a short observational framework for inspection (SOFI) to capture the experiences of people who may not be able to express themselves or communicate with us.

Inadequate

Our findings

During inspection, we were made aware of concerns surrounding the management of medicines at the service. This included failing to order medicines from GPs in a timely manner. A review by the medicines optimisation team in May 2017 found that there were insufficient medicines for people and significant gaps on medicine administration records (MAR's).

During this inspection, we found further action was needed. We observed part of a medicines round and observed that the nurse signed the MAR before they had given the medicines to the person. We identified gaps in MARs which meant it was not always clear if prescribed medicines had been given. No quantities of medicines had been recorded on the MARs which meant that it was unclear how much stock each person should have in place at the service. This is important to ensure that people always have enough medicines. Where medicines had been refused, no reason for this had been recorded. On the second day of inspection, we observed a nurse leave the medicine trolley open on the first floor when they left to answer the telephone and on the third day we observed that a locked medicine trolley had been left in the corridor on the ground floor. It had not been secured to a wall or locked away in the clinic. We saw two confidential care plans for different people relating to their medicines had been left on the trolley.

During the inspection, the Commission received information about one haloperidol medicine which was found by staff on 18 May 2017. Records showed this was disposed of appropriately, however no incident record had been completed in respect of this.

Medicine protocols for people lacking capacity did not contain the information needed. For example, one person needed PRN (as and when) medicine for pain relief and could not speak English. The nurse on duty told us about the signs and symptoms this person could display when they needed pain relief, however this information was not in the protocol. Agency nurses on duty at the service would not have known this information.

Three people received their medicines, which staff crushed via their percutaneous endoscopic gastrostomy (PEG) feeding tube in their stomach. No procedure was in place for crushing medicines and staff had failed to seek guidance in relation to this. Crushing tablets removes the license for the medicine and makes them an unlicensed medicine. One person had been prescribed modified release capsules. This meant that if the modules in the capsules were crushed then the person could receive too much medication. No risk assessment was in place for this. We asked the registered manager to seek advice about crushing medicines and ensure a procedure and risk assessment was put in place.

People were not receiving their topical creams as prescribed. Topical medicine cream records (TMARs) were not up to date and there were no TMARs in place for some topical creams looked at. Topical creams did not routinely contain a date of opening. Staff had not taken action to seek clarification where guidance was unclear. No action had been taken to address this following feedback on the first day of inspection.

Nutritional supplements were stored in corridors and bedrooms and next to windows. This meant that people's supplements privacy was not protected because their personal information was on display. We asked staff to take immediate action to address this. Following a complaint from a relative, they were removed from one person's room but not from any other rooms or communal areas.

Staff were not always responsive when people's needs changed. One person suffered a burn to their skin from a beaker of coffee on 16 June 2017. On 18 June 2017 care records stated that a blister from the burn had burst and the wound was sore. The GP was not contacted until 19 June 2017 and a prescription for Flamazine cream was issued, however this was not collected until 23 July 2017. This meant there was a delay in seeking appropriate treatment. The prescription for Flamazine said, "To apply every 2-3 days," however the MAR for this topical cream showed it was applied for two days consecutively and on the third day, "omitted due to instructions." These errors had gone unnoticed.

Staff recorded when one's person skin became inflamed and noted green discharge on 2 July 2017. A nurse recorded that the district nurse would be contacted on 3 July 2017. We observed the district nurse attended for this appointment on 3 July 2017 who and updated their records to show that they had looked at this person's foot which they had been receiving treatment for. Staff failed to inform the district nurse of this new concern or ensure that this person received the treatment they needed. We spoke with the registered manager and they took immediate action to get in contact with the district nurse and they returned later that day.

One person told the nurse on duty on 3 July 2017 that they were experiencing pain early in the morning. By lunchtime, no action had been taken to investigate the cause of this pain and determine whether any further action was needed. We raised a safeguarding alert for this person.

Staff were not responsive or alerted to health and safety checks of people using the service. Prior to inspection, we were aware of an incident where one person had been left for three hours without the care and support needed. They had not suffered any harm and the service had raised a safeguarding alert. The registered manager confirmed that no health and safety checks of this person had been carried out. The registered manager told us that one hourly health and safety checks of everyone using the service should be carried out; however they did not complete records when these checks were made. We were concerned that regular health and safety checks of people were not carried out because some people were unable to use their call bells and had no way of alerting staff. Another person was subject to 30 minute health and safety checks but there was no information in the person's care records to show the reason for this. The nurse on duty did not know about these 30 minute checks and these checks had not been carried out consistently.

Consistent action was not taken when people were at risk of experiencing falls. One person had experienced seven falls which had been documented in their care records, however incident forms had not been completed in respect of four falls. The care records stated that more frequent observation should be carried out to reduce the risk of harm; however there was no evidence of any checks. These falls had not been recorded onto local authority consideration records. Despite this person experiencing falls, their falls risk assessment had not been reviewed since 4 May 2017. This last risk assessment which showed this person was deemed at high risk of falls. The guidance available on the back of the falls risk assessment stated that the person should not be left in isolated positions during the day and there should be an increase in the

frequency of monitoring. During each day of inspection, we observed this person to be isolated in their room.

Staff were not responsive to people at risk of developing pressure sores. One person showed us an open wet wound with green discharge which had a malodour on their hand. We noted no appropriate dressing had been put on this wound. In the care records this wound had been recorded as a bruise on a body map dated 4 April 2017. On 12 April 2017, a body map stated that three skin tears had been sustained and a dressing to the left hand was in place. We noted this person had a skin tear on the back of their knee which was documented and had a dressing applied. The dressing was dated 27 June 2017 which meant it had not been changed for six days. The dressing was dirty. A care plan for this wound showed there was a skin tear on 4 June 2017 and a dressing was applied and should be left for 5-7 days. The next entry dated 14 June 2017 showed the wound was reassessed. The continuous wound re-assessment record had only been completed on 16 June 2017 which stated that, "Wounds should be re-assessed weekly as a minimum." Between the dates of 4 June and 3 July 2017, only one assessment had been carried out. We raised a safeguarding alert for this person.

People who needed to move position regularly to reduce the risk of developing pressure sores were not supported appropriately. Staff did not follow guidance in relation to positional changes. People assessed as needing two hourly turns were left up to five and half hours without being moved. One person required a specific pillow when laid on their back. We observed this person laid on their back and this pillow was on the floor. This meant people had been exposed to the risk of developing pressure areas due to staff failure to follow guidance.

During the inspection, we received whistleblowing concerns about moving and handling at the service. The provider investigated these concerns and two staff were subjected to disciplinary procedures.

We identified that the service did not have enough hoists to use on the first day of inspection. We observed staff looking for and waiting for hoists and could see people experienced delays receiving the care and support they needed. One staff member told us, "Residents get mad because we are late for them because we are waiting for the hoist." The registered manager told us that some hoists had been taken for repair and had not been replaced. During this time, the provider had placed an order for new hoists and stand aids which they were waiting for. No proactive action had been taken to address the shortfall. Following our request, the registered manager obtained another hoist from a service within the provider's portfolio. On 3 July 2017, staff told us they did not know how to use the new hoist and had not received any training. The registered manager told us training was not needed however staff told us they were not confident in using it because it was one they had not used before. There were 61 slings in place at the service, they had not been allocated to people based on their individual needs. We found most slings stored away in a cupboard. When we spoke with staff they told us there was a shortage of hoists. This meant guidance from assessments on which sling to use wasn't being followed.

Procedures for managing infection prevention and control needed to be improved. We asked twice for an overflowing bin containing incontinence pads to be emptied because of the malodour it was creating in a bathroom. During the inspection, staff complained that there were not enough incontinence pads and disposable gloves at the service. We identified that there were enough incontinence pads, however they were not readily available and accessible to staff when they needed them. Again, disposable gloves had been available but were not in clinical areas for staff to use and had only been available in a large size. This meant staff did not have readily available access to resources needed to provide safe care and support to people

Bathing temperature records showed that people had bathed in unsafe water temperatures on 20 occasions between 29 January and 30 June 2017. The low bathing temperatures recorded such as 20, 22, 23, 30, 35 and 36 degrees Celsius had not been highlighted during quality assurance checks at the service. We noted that water temperature checks had been regularly completed by the maintenance team and checks found to be within safe water temperature limits. This meant that staff had ran baths for people which were too cold.

These concerns form a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were enough staff on duty, however staff told us this was not the case. Staff told us there was frequent staff sickness and some staff had not turned up for work. One staff member told us, "Staffing levels need improving. We need to look at dependency levels. We are pushed with current staffing levels. To do things with dignity takes time. To promote independence takes time. Logistics makes it difficult." Another staff member told us, "Staffing at weekends is poor. We struggle to meet people's needs when staff ring in sick." One person told us, "I think there is [enough staff] during the day, but maybe more on a night [are needed]." Another person told us, "Some days there isn't [enough staff], and they seem short staffed but it's alright." A staff member told us, "We have enough staff when we are at capacity, but we can be pushed. It's hard when there is staff sickness."

Staff expressed their concerns that people were not receiving the care they need because of insufficient staff. One staff member said this was 'abusive practice.' Other staff told us people got up late because they were waiting for staff to attend to them. One staff member told us, "We are abusing people when we are late for them and when they are left wet." Another staff member told us, "We are not getting done until 12 [noon]. It's not fair on the residents. We have to help out on other corridors due to sickness. I feel worn out and the residents are not getting the care needed."

During the inspection, we saw that staff were always visible on the ground floor of the service, but less so on the first floor. We noted that there could be no staff on the first floor at times because care staff could be assisting people to go downstairs for meals or activities and the nurse could be called away to assist with medicines on the ground floor. We saw that call bells went unanswered. During a visit to one person on the first floor, we pressed their call bell for assistance and we did not get a response from staff because they were assisting other people. Staff from the ground floor did not respond. One relative told us they had raised concerns with a nurse about call bells, after their relative waited for 30 minutes without a response. They told us they were dissatisfied because no action had been taken to address this.

Staff on the ground floor were not deployed appropriately. Staff were not always visible in the corridors they were allocated to and call bells were unanswered for long periods of time. There was no consistent leadership in place to ensure staff on the ground floor were carrying out the duties expected of them. We observed staff together in groups of three chatting or going outside on their break.

People on the first floor told us they did not like to go downstairs because they could be left for long periods of time. One person told us, "If I go downstairs for lunch, I'm sat there for an hour before [the meal arrives] and it's ages before we come back up."

On the 3 July 2017, we observed a singer performing for people. The activities coordinator was left in the dining room with 17 people. They left with one person when they became unwell. The remaining people were left unsupervised. Although there were enough staff on the ground floor, no staff supported / relieved the activities coordinator. People were placed at potential risk due to being left unsupervised.

These concerns form a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training in safeguarding had taken place but competency assessments were needed because staff had not always raised concerns when needed to. This meant staff did not fully understand their roles and responsibilities to protect people from harm and abuse. During this inspection we raised safeguarding alerts for four people because they were not receiving safe care and support. Where concerns had been raised, investigations had taken place and procedures put in place to minimise the risk of re-occurrence.

People told us they felt safe living at the service. They had confidence in the staff team to keep them safe. One person told us, "Yes, there is everything to feel safe about, the staff are really good." Another person told us, "Yes, I do feel safe in here, I've got no problems." We also spoke with people's relatives and they confirmed that people were safe at the service. One relative told us, "The staff are good and I feel they are in a safe environment." Another relative told us, "The staff are really good towards [person using the service]. I believe they are safe and well at the home."

Some people required controlled drugs. These are drugs which are liable to misuse. Regular checks of these drugs had been carried out and records completed when these drugs were dispensed to people. We checked a sample of the drugs and found quantities matched the controlled drugs records.

People told us staff were confident when providing assistance to them and felt safe during transfers in hoists. One person told us, "I'm happy with the staff using the hoist and I feel safe." One relative told us, "Everything is fine, I've witnessed [person using the service] being moved in a hoist and there were no problems."

Each person had a personal emergency evacuation plan (PEEP) in place. These detailed records provided information about important health conditions, any difficulties with mobility and the assistance required by staff to safely evacuate the service in an emergency situation.

Health and safety checks of the building had been carried out to ensure that it remained safe for people using the service and staff. This included a gas safety certificate, checks of stair lifts and portable appliance testing. Fire safety checks were up to date and we saw staff had participated in regular fire drills.

Recruitment procedures were in place. In the five staff recruitment files reviewed, we could see appropriate checks had been carried out. This included two checked references for each applicant and a Disclosure and Barring Services (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Requires Improvement

Our findings

The registered manager had failed to ensure people at risk of malnutrition were not regularly monitored by staff because they failed to ensure weekly weights were carried out, inaccuracies in the records went unnoticed and care plans and risk assessments were not regularly updated. For example, records showed that one person who needed to be weighed each week had only weighed on 11 occasions between 7 June 2016 and 7 May 2017. This person had lost 5.8 kilograms between 10 September 2016 and 1 October 2016. Care records did not show what action had been taken in response to this weight loss. In care records looked at body mass index (BMI) recordings were noted to be inaccurate on some occasions and not recorded on other occasions and some nutrition risk assessments were incomplete. This meant staff were not robustly monitoring people at risk of malnutrition.

Food and fluid balance records were not routinely completed. Fluid records did not contain information about the volume of fluids each person needed to consume each day and fluids were not totalled up each day. There were no systems in place to show what action had been taken where food and fluid balance intake was low. For example, we reviewed one person's records on 22 May 2017 at 13:02 and found they had consumed 90 millilitres of fluid that day and had consumed 725 millilitres of fluids the previous day. This meant this person was at risk of dehydration.

On 3 July 2017, we visited two people in their rooms between 11:00 and 11:30 and identified they had not received their breakfast, despite being awake since early morning. We visited the kitchen to ask for breakfasts for these people and found that staff were in the process of preparing and cooking lunches. These people were on different floors of the service and both had gone unnoticed by care and kitchen staff. We noted that one person was a type two diabetic and was at risk of experiencing a deterioration in their health because they had not eaten regularly.

Some people were given their food and fluids via their percutaneous endoscopic gastrostomy (PEG) feeding tube in their stomach. No records were in place to show people had been given food and fluids or the PEG site had been cleaned and the balloon deflated. This meant we could not be sure if people were receiving safe care.

These concerns form a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff participated in mandatory training. This is training which the provider deemed necessary for staff to

carry out their role. At this service, this included managing behaviours which challenge, moving and handling, safeguarding adults, fire safety, infection prevention and control and the Mental Capacity Act 2005. A training summary record dated 1 June 2017 showed that some areas of training were not up to date. Out of 73 nurses and care staff, 54 had completed pressure ulcer training, 43 had completed moving and handling training and 42 had participated in a planned fire drill. . This meant staff may not have the required level of training and competence to support people safely and appropriately. No competency checks for using a new hoist had been carried out for staff.

Staff had not received training in providing care and support to people living with a mental health condition, learning disability or Parkinson's disease. Two staff told us that they needed training in learning disabilities. One staff member told us, "Some residents get snappy [towards people living with a learning disability] and can be cruel towards them." Training records showed staff had received training in managing behaviour that challenges, however staff told us they lacked confidence in putting these skills into practice. Care records lacked information about de-escalation techniques which staff could utilise. One staff member told us that one person could hit out at staff, but staff were not trained to deal with this.

These concerns form a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt well cared for by staff. One person told us, "The staff are very friendly and if you have any problems or feeling a bit low, you can talk to them." Another person told us, "They look after me much better than I could look after myself at home, and that's really important to me." A third person told us, "It's a caring environment and the staff are really special."

People and their relatives told us they were confident that staff would have the necessary training to perform the duties required of them. One person told us, "They [staff] work together as a team and they really get to know us." One relative told us, "They [staff] appear well trained." Another relative told us, "[Person using the service] has never experienced any problems and I believe they [staff] are well trained."

All staff were supported through their induction, which included shadowing more experienced staff, undertaking training and becoming familiar with people and the day to day running of the service. The provider had identified some gaps in induction and action was being taken to address this.

Staff told us they felt supported to carry out their roles and had received regular supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Some supervision sessions included key themes following events at the service. This meant the registered manager had taken action to ensure lessons had been learned. The registered manager had identified that not all staff appraisals were up to date; however an action plan was in place.

People told us they enjoyed the food and drinks given to them at the service. One person told us, "[The food] it's better than anywhere else I've been." Another person told us, "The food is always hot." A third person told us, "The food is usually very good." People told us drinks and snacks were available outside of mealtimes and alternatives were always available if people did not want to eat the meals on the menu. One person told us, "If you get things [food] you don't like, you just ask to change it. The sweets are lovely."

Staff supported people who needed assistance at mealtimes. The atmosphere in the dining room appeared relaxed with background music on. A four-week rolling menu, which included photographs, was in place for summer and winter, although alternative choices were always available for people. We observed people being given alternative choices during inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, there were 10 people who had an authorised DoLS in place; we could see that people had these in place to maintain their safety or to provide support with personal care, eating and drinking and medicines management. The registered manager had a tracker in place which showed when each person's DOLS authorisation had been granted and when it was due to expire. This prompted the service to make sure that a review of these deprivations took place prior to the expiry of the authorisation.

Best interest decision making had taken place for people. Records were in place to show the reason for the decision being made and the people involved. Independent mental health advocates had been involved with some people to ensure they voice was heard.

People told us that staff always sought their permission before any assistance was provided. One person told us, "They [staff] always ask if they can do things beforehand." Another person told us, "It's on-going consent if you like, but they do ask, yes." A third person told us, "They [staff] always ask for permission."

Some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' orders in place. These had been reviewed regularly to ensure they remained in date. Certificates showed the reason for this decision making and the people involved.

People had regular access to health and social care professionals involved in their care. This included their GP, dentist, tissue viability nurses, opticians and dieticians. A local GP surgery attended the service each week to carry out a review of people's health conditions and medicines. Everyone we spoke with confirmed that health professionals regularly attended the service when they needed further support. Care records included details of these visits and care plans were updated to reflect advice given. One person told us, "If I need to see someone [health professional], they come here. A relative told us, "If [person using the service] needs a doctor, they come out to the home and the staff make all the arrangements. They [staff] also keep me informed."

A nurse responded quickly when one person became unwell with a chest infection. They had identified a lack of information in hospital transfer records and acted quickly when a relative provided important information to them. The nurse contacted the person's GP about this infection and to seek their advice about using oxygen.

Steps had been taken to create a dementia friendly environment at the service. We noted that garden areas were large with flat areas. There were dementia friendly signs on doors and in bathroom and lounge areas to help people orientate themselves around the home. The registered manager told us they were in the process of introducing memory boxes.

Requires Improvement

Our findings

People's privacy and dignity was not maintained or respected. One person using the service did not speak English. Staff did not speak this person's language. This meant the person could not communicate effectively with staff. Staff had picture cards in place to use with this person but had not accessed other means of communication such as communication applications on tablet style computers. There were no details in this person's care records about key words which staff could use and this person had no access to anyone on a regular basis who could speak the same language as them. We could see the registered manager had contacted a local religious organisation for assistance. Following our concerns about this person, the registered manager identified a volunteer who agreed to provide two hours companionship each week. We noted that this person had remained isolated since they moved into the service without appropriate provision made available to them.

People told us their privacy and dignity was maintained when we spoke with them. One person told us, "If I go to the bathroom, they close the door. I can take a bath anytime I want and they respect my privacy." Another person told us, "Its top notch, they always close the door if they are attending to me." However we found that this was not always the case.

Prior to inspection we were aware that one person had had their privacy and dignity compromised because they had been left on the toilet for three hours. A call bell was not within reach. Night staff left the person on the toilet because they had been called away to an emergency and had failed to hand this over to day staff. The registered manager told us staff should have carried out hourly checks on all people using the service. This had meant this person had gone unnoticed. We spoke with people during the inspection and we were confident that no-one else had experienced this.

On the first day of inspection, we raised concerns about the privacy and dignity of people because continence pads, nutritional supplements and urine drainage bags for people with catheters were on display and drinks and call bells were not within reach. We observed three occasions where staff walked in front of one person in their electric wheelchair to get past them, causing the person to stop. We noted staff did not allow the person the time they needed. Action was taken by the registered manager to address these areas.

On the third day of inspection, we observed a nurse walk into a person's room without knocking. We noted that this person was receiving personal care from another staff member at the time. This evidenced a lack of respect for the person.

We visited one person in their room around 11:00am and found that the person had been incontinent waiting for staff. There was a soiled incontinence pad on the bedside table next to the person and there were faeces inside and outside of the toilet bowl. We visited another person in their room around 11:30am. The person had also been incontinent waiting for staff. Staff told us that one person's electric wheelchair was not regularly charged. Another staff member told us this caused delays when assisting the person to get ready for their day as well as to access communal areas. We raised safeguarding alerts in relation to these people

These concerns form a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they were happy with the care and support provided to them and were complimentary about staff. One person told us, "The staff are very good." Another person told us, "The staff are very friendly and helpful." One relative told us, "I believe they are responsive and very attentive towards [person using the service]."

One person told us, "The staff do lots of things and they do all that they can to help." People described staff as, 'brilliant,' 'good' and 'respectful.' Staff told us they enjoyed their roles. One staff member told us, "I love care; it's all I've ever done. We give people the support they need." Another staff member told us, "It's very rewarding."

People and relatives told us that staff worked together as a team to provide a high standard of care each day. One person told us, "Staff are all very friendly and easy to talk to." Another person told us, "No complaints with any of the staff here. You can see the management anytime you want to sort anything out." From our observations, we could see that staff knew people well. Staff appeared friendly and relaxed during their interactions with people and relatives.

People told us staff were caring. One person told us, "Actually, it's a miracle because I've seen things on the television which worry you. They [staff] all seem to be caring which is essential." One staff member told us, "We all love our jobs. It's rewarding when you help people and feel appreciated."

People had confidence in staff to be available when they needed care and support. One person told us, "They [staff] look after me really well." Another person told us, "The staff will do anything for you." A relative told us, "The staff are extremely caring towards [person using the service]."

We observed a staff member assisting one person in a communal area to put on a cardigan. The staff member gave the person time, enabled the person to do what they could and communicated with them throughout. The staff member was polite and pleasant and provided reassurance. They made sure this person was comfortable and checked to see if they had everything they needed before they left.

Staff supported people to remain independent. Care records included information about what people could do for themselves and when they needed support. People who used electrical wheelchairs and walking aides told us staff prompted them to use their equipment.

People and their relatives told us they felt involved in their care. We could see some people were involved in formal planning and reviews of care and were aware of their care plans. One person told us, "I have seen my care plan and there is a copy in the room." Another person told us, "I do see it [care plan] when it needs changing. I can look at it anytime, nothing is hidden." Other people were involved in more informal ways, which was their choice, such as discussions with staff and the registered manager. These discussions were

recorded and care records updated. One person told us, "I speak to staff about what I need." Another person told us, "Everyone is open to suggestions about my care."

Staff were aware of advocacy services and information about these was on display in communal areas. This is a means of accessing independent advice and support with decision making. We could see from our review of care records that some people had used advocacy services.

People and their relatives told us the registered manager and staff were always available to them if they needed to discuss their care and there was no limitation on visiting hours. We observed relatives spending the day with some people and others popping in. One relative told us, "I visit [person using the service] every day. I arrive at the home about 10am and stay until about 8pm every day."

When people moved into the service, some did not have the things they needed. Staff liaised with social workers to obtain funding for people to ensure they had items such as clothing and toiletries. Staff told us funding could take some time, and most recently one staff member supplied one person using the service with the items they needed until their funding was agreed.

The clinical services manager told us that one person had been supported to move rooms. They had felt isolated and had moved to a room in a busier area of the service. The clinical services manager told us this had a positive effect on the person.

Some people were receiving end of life care at the service. Care records included information about people's preferences, any equipment and specialist medicines to ensure people remained comfortable. The registered manager told us that a 'future decisions' record will shortly be introduced which will incorporate end of life care.

Requires Improvement

Our findings

Outside of planned activities, there was a lack of meaningful activity for people. We observed people in their rooms and in communal areas without stimulation. In communal areas, televisions were on but we saw that people were not watching them. People were sat in silence. We did not observe staff sitting and chatting with people outside of care and support activities. We also observed three people who were in bed during both days of inspection and found no stimulation in place for them.

We visited one person in their room and they asked us if they were allowed to get out of bed. We reassured the person they were and asked the registered manager to take action. The person told us they sometimes sat in their chair but had been left in it for six hours which was too long. Care records showed that a district nurse had shared concerns that this person spent long periods of time in bed.

Daily records did not reflect care plans. Staff were not aware of people's individual needs, wishes and preferences because they did not read care plans. Staff told us they did not have time to do this. We observed one person laid in bed during the day. The person's care plan stated they liked to be sat up in bed. The person had not received care according to their wishes.

These concerns form a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's personal information was not protected because we found care records on display on each day of inspection in communal areas such as a lounge and corridors. This meant people's information was not being stored confidentially and was available for anyone to read.

We also found that some staff had not followed the provider's values, policies and procedures because information relating to the service and to people was shared with members of the public. The provider took immediate action to address this in supervision and staff meetings. An internal investigation was also carried out.

During the last year, two safeguarding alerts had been partially upheld in respect of record keeping. This meant that accurate and contemporaneous records had not been kept.

During this inspection, we identified concerns in relation to the quality of record keeping at the service. We found gaps in records because staff had not consistently completed them and we also found that some

records which should have been in place were not. We noted that one person had a health condition which required specific care and there was no care plan or risk assessment for this.

Care records were not always completed when people moved into the service. One person had been admitted to the service on 19 May 2017. A preadmission assessment had been completed; however, no care plans had been completed. Food and fluid balance records for 19, 20 and 21 May 2017 had not been completed despite risks in place. The regional manager told us that mandatory care plans should have been completed within 72 hours.

Another person was admitted on 15 June 2017 for respite. A risk assessment for falls had been completed on 15 June 2017 however risk assessments for safe handling, wheelchair and pressure care had not been completed until 28 June 2017. At inspection on 3 July 2017, care plans had not been completed. Professional visit records showed professionals were involved for falls, physiotherapy and continence care but as care plans had not been completed, it was unclear about the reasons for this. Physiotherapy recommendations dated 28 June 2017 were not detailed in the care plan either. Daily records for this person were completed on 15 June 2017 at 12:45 made reference to the person's admission; however, no further entries were recorded until 16 June 2017 at 05:00. An entry on 17 June 2017 stated, "Unable to find daily notes from when [person using the service] was admitted on 15 June 2017. This incident had not been reported by staff or recorded on an incident record and the registered manager was unaware of these missing records.

For both of these people, staff did not have the information they needed to provide care and support which reflected people's needs, wishes and preferences. Staff involved in the care of these two people had failed to communicate this omission to the registered manager and concerns had not been flagged up during quality assurance procedures.

Care plans were not regularly updated. For example, care plans for safety, going to the toilet and moving around for one person at high risk of falls had not been reviewed since 16 May 2017 and the person had experienced three falls since this time.

Care records contained information which was inaccurate. For example, one recorded stated that the person was aware of their own safety; however the person was living with dementia and had experienced falls trying to walk to the bathroom.

A personal emergency evacuation plan was in place for one person who did not speak English. There were no key words in the plan which emergency services or staff could utilise to inform the person that there was an emergency and to reduce any distress.

These concerns form a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some care plans in place which did reflect people's individual care needs. These were accompanied by risk assessments where needed. These care plans outlined people's needs, wishes and preferences and what was important to them such as religious visits, contact with family and friends as well as hobbies and interests. These care plans provided information about people's life histories likes and dislikes as well as the care and support they needed. Care plans showed what people could do for themselves; this meant staff could be proactive to help people to remain independent.

The activities coordinator was responsible for organising planned activities, carrying out meetings for

people and their relatives to obtain feedback and to update them about any changes occurring at the service, as well as producing a newsletter. Information about planned activities was on display in communal areas of the service and people spoke positively about these. One person told us, "I indulge in the odd quiz." Another person told us, "I play bingo and I go to the quiz sessions. I also go to keep fit classes." A third person told us, "I'm bed bound but they brought a tiny horse into my room last week." A fourth person told us, "I go to the bingo and the quiz, and I enjoy it when they bring the pets into the home."

The activities coordinator told us that each person using the service was offered one-to-one time each week. For people who spent time in their rooms or were nursed in bed, activities included, hand massage, reminiscence and games. People and their relatives told us that a variety of planned activities had been put in place for people and consisted of bingo, quizzes, sing-alongs and weekly visits from one of the staff member's ex-guide dog. People told us Zoo lab and a therapeutic pony had also visited them. We observed two external activities taking place which the activities coordinator had organised and we saw people participating in the activities and smiling. People told us they enjoyed the drinks and do noughts which had been provided during the activity.

People told us they spent time in the garden and enjoyed views of this from their room and views of Eston Hills. People had access to newspapers and sometimes went out into the local community with staff. During the inspection, we observed a pre-booked entertainer at the service. Many people attended this session and appeared to enjoy themselves. Completed records were in place to show that people had been involved in activities.

The activities coordinator had organised regular fairs to raise money for extra equipment for the service. Most recently, a Karaoke machine and a DVD player had been purchased for people to use. The service created its own calendar, with pictures provided by one person using the service. All proceeds were put into the residents funds.

People told us they knew how to make a complaint and we could see from available records that complaints had been made. We noted that the number of complaints had reduced since the registered manager came into post. People and relatives told us they had confidence in the registered manager and that appropriate action had been taken when they had raised a complaint. Records of complaints provided details of investigations, action taken to resolve each complaint and an outcome.

We received a number of complaints via the Commission during this inspection process. We shared this information with the local authority safeguarding and commissioning teams, with the provider and also included the concerns into the planning and inspection process.

A relative had contacted the Commission with a compliment about the service. They told us, "Outstanding care offered for the time to think beds. Gave people another option rather than staying in hospital and taking up NHS resources. [Registered manager] gave reassurance and care to people so that they became more prepared to return to their own homes. Manager gave up much of his personal time outside working hours to speed up the admission procedure to get people in a more comfortable place. [Registered manager] didn't have to do that but just showed how much he cared."

Inadequate

Our findings

We spoke with the registered manager about the quality of record keeping at the service and asked them to take immediate action to improve these. Extra staff were brought in to check all care records and improve the standard of them. They told us all care plans and risk assessments would be reviewed. No improvements were noted to the quality of record keeping on the second and third day of inspection and care plans had not been reviewed.

The registered manager told us they were already aware of gaps in records and had put measures in place over the last six months to improve the overall quality of records. We could see that record keeping had been discussed during staff supervisions and some audits had identified some of the gaps which we had identified, but not all. Although staff had received supervision about record keeping, we found they did not highlight any specific gaps in records with the registered manager so that action could be taken. When we spoke with staff about record keeping, they told us the care of people came first and the lack of staff impacted upon their ability to meet people's needs and complete records.

A nurse was employed three days per week to complete care plans with people when they moved into the service, to review care plans and ensure they remained accurate and up to date. Nurses were also allocated to specific people to ensure records were kept up to date. This meant that a nurse who does not carry out clinical duties at this service is planning and reviewing care plans of people they are not familiar with. We also found with the system that care plans were not always in place, had not been consistently reviewed and the quality of record keeping was poor.

Although audits were in place, they had failed to address all of the issues which had been identified during this inspection. This included record keeping, inconsistent reviews of care, poor medicines management, incident reporting, poor care, staffing levels, call bells, staff training, maintaining dignity, responding to people who experienced a deterioration in their health condition, providing person-centred care and inappropriate storage of nutritional supplements. It was clear that audits had not all been carried out in a timely manner and audit information was not always clear. We also disputed some of the information contained in audits. For example, a care plan audit completed on 10 April 2017 was scored 90% however our findings during this inspection did not support his. Audit information was not shared with staff to show where improvements were needed. Actions put in place as a result of audits were not always followed through. For example, as a result of a nutrition audit carried out on 9 May 2017, all nurses were asked to sign supplementary records at the end of their shift to show the records had been fully completed by care staff and people had received an adequate food and fluid intake. From the records reviewed, we could see nurses

had not completed this action.

A key information board had been introduced in the nursing office. The aim of this was to make sure people at risk were receiving the care and support they needed. Given the findings from inspection, we questioned whether staff had been using this information during handovers and during reviews of care. We noticed there were omissions in the information on this board because we found that columns for nutrition risk scores and additional comments had only been included for half of the people using the service.

A strong and stable team who were supportive of the registered manager and each other was not in place at the service. The provider was taking action to support staff to address this. Leadership was in place but required improvement at all levels to ensure all staff were carrying out the duties expected of them. There was no accountability in place when staff had not completed records or not responded to people's changing needs in a timely manner.

We spoke with the regional manager and registered manager about our concerns throughout this inspection. They listened to our concerns and carried out investigations where we asked them to. Although some actions were taken to make improvements, there was a clear deterioration in all areas of concern between the second and third day of inspection.

We asked the provider to consider placing a voluntary embargo on the service, which means they cannot admit any new people to allow the service time to make the improvements needed. The provider agreed to this without hesitation. Since inspection, the provider has increased the support at the service for the registered manager and staff. They have regularly communicated with us. We wrote to the provider outside of this inspection process to share our concerns with them and have asked them to address these concerns and provide us with an action plan. We have also shared our findings with Redcar and Cleveland local authority commissioning and safeguarding teams and South Tees Clinical Commissioning group.

These concerns form a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been made aware of our concerns relating to the service, however most staff were supportive of the registered manager. One staff member told us, "Since [registered manager] came on board on August 2016, this home is a much better place. We have seen positive changes since [registered manager] came on board. The home has had managers come and go over the last few years and now we have a manager in place that cares about the future of Hillview. As a team of positive staff, we want this home to thrive and succeed. We have an excellent manager in place and we are behind them all the way." A staff member told us about the positive support they had received from the registered manager with their health condition. They also told us, "I feel I have a real chance at a promising future while working with [registered manager]. He is a good manager and should be recognised as such. With the right support and the right team [registered manager] can really make a difference in this home."

Staff told us they enjoyed working at the service and told us they felt supported by the registered manager. One staff member told us, I enjoy my job and looking after people. [Registered manager] is canny. I hope they will stay. Another staff member told us, "I really enjoy my job. [Registered manager] is great, approachable and friendly." A third staff member told us, "It's different since [registered manager] came. People are happier. If [registered manager] can help you they will."

People and relatives knew who the registered manager was and told us they were always visible. People described them as 'friendly' and told us they saw the registered manager often and they always said, "Good

morning" to people. A staff member told us, "[Registered manager] is alright. He's fair and approachable."

Prior to inspection, we were aware that the clinical commissioning group and local authority had been supporting the service to make improvements. The registered manager told us that significant improvements had been made since they began their post on 1 August 2016. We noted that the number of complaints, safeguarding alerts and infections had reduced. The number of chest and urinary tract infections had significantly reduced.

People and their relatives were invited to attend residents meetings. These informed people about upcoming events and changes to the service. We could see from the minutes, that people and their relatives had used this opportunity to discuss concerns about the service with the registered manager. We could see over the course of the year, the number of complaints raised during these meetings had significantly reduced. In the most recent meeting, one person had 'given credit to carers and all staff and had pointed out that they had a difficult job to do.' We could also see that requests from people had been actioned; this included internet access for people with their own tablets. People and their relatives were also kept informed of events through the services newsletter's.

Staff meetings provided staff with the opportunity to seek information about changes to the service, areas of risk and training which they needed to attend. We could see that staff meetings for particular staff areas had been held where concerns had been flagged. Staff forums were also held by the provider during this inspection to allow staff to discuss any concerns which they had.

The service had good links with the local community, this included schools, local Catholic and Mormon Churches and the Salvation Army. The service worked alongside the clinical commissioning group and local authority safeguarding and contracts and commissioning teams. They attended safeguarding meetings when needed and ensured all relevant information was made available. The registered manager had submitted notifications to the Commission when they had been an incident at the service.

The latest survey for people using the service had been carried out in 2016 and was completed by seven people. We noted that all seven people were happy with the care they received, felt safe and listened too and were felt they were treated with dignity and respect.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1) 1.The care and treatment of service users must a. Be appropriate, b. Meet their needs, and c. Reflect their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 10. (1) Service users must be treated with dignity and respect. (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular a. ensuring the privacy of the service user; b. supporting the autonomy, independence and involvement in the community of the service user; c. having due regard to any relevant protected characteristics (as defined in section

149(7) of the
Equality Act 2010) of the service user

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines;

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (2) a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c. maintain securely an accurate, complete and contemporaneous record in respect of each

service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 18.— 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2.Persons employed by the service provider in the provision of a regulated activity must a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

The enforcement action we took:

We issued a warning notice.