Milestones Trust

Hillside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 11 and 12 May 2017. The inspection was unannounced.

The service provides care and accommodation for up to 16 people with a learning disability. At the time of our inspection there were 12 people living in the home.

There was a manager in post and they were going to begin the process of registering. The manager who was registered for the service with the Care Quality Commission, had left the service but their application to deregister had not been received. 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.

There were some shortfalls found during our inspection. However, the manager had already identified most of the concerns we found and incorporated them in to an action plan. A number of records we found required updating to ensure they reflected people's current needs and preferences. This included care plans and 'essential lifestyle plans' that identified goals that people were working towards. The manager had begun updating records; initially concentrating on health action plans, but other records were also identified as a high priority to address.

There was evidence that staff understood the principles of the Mental Capacity Act 2005. Staff were able to describe to us important aspects of the Act such as the assuming people had capacity unless it was assessed otherwise. There was also evidence of best interests decision making for those people who had been assessed as lacking capacity. We did find one example of a decision that had been made without a capacity assessment or best interest decision in place. Five people in the home had Deprivation of Liberty Safeguards in place. Some of those people had conditions on their authorisation but it was not clear that these conditions had consistently been met. We also found that notifications about these authorisations had not been made to the Care Quality Commission as required by law.

People in the home were supported by a caring group of staff who understood the needs of the people they supported. Staff supported their communication with sign and gestures and this ensured that people received reassurance when they sought it. During our inspection, we observed many positive interactions between staff and people in the home and people were settled and content in the presence of staff. There were sufficient number of staff on duty and numbers had recently adapted in recognition of the increased needs of people in the home.

People were able to go out in the local community independently if it had been assessed as safe to do so. Those people requiring support outside of the home also had opportunity to go out, for example to local shops. There were activities available in the home for people to access if they wished to, such as a pool table and arts and crafts.

People received safe support with their medicines. These were stored and administered safely.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse because staff had received training in safeguarding adults and knew the reporting procedures to follow.

There were risk assessments in place to guide staff in providing safe support for people.

People received support to take their medicines.

There were sufficient numbers of staff to support people safely.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

Some people had DoLS authorisation in place but it wasn't clear that the conditions on them had consistently been met.

Not all staff had received regular supervision or an annual performance and development review. This was being addressed by the manager.

People received support to see healthcare professionals when they needed to.

People were supported to receive good nutrition.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach and communicated well with the people they supported.

People were supported to maintain contact with people who were important to them.

People were able to give their views and opinions about their own support and the running of the home.

Is the service responsive?

Requires Improvement

The service was not responsive in all areas. Care plans needed reviewing and updating to ensure they reflected people's current needs and goals.

People were supported to make complaints but the system for logging complaints required updating.

Staff were knowledgeable about the people they supported.

People were able to take part in activities both in and outside of the home.

Is the service well-led?

Requires Improvement

The home was not well-led in all areas.

Not all notifications had been made to the Care Quality Commission as required by law.

Many but not all shortfalls found at our inspection had been identified by the service's quality monitoring systems.

Staff were positive about working in the home and reported working well together as a team.

Hillside

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide an updated rating for the service under the Care Act 2014.

This inspection took place on 11 and 12 May 2017 and was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection, we reviewed all information available to us, including notifications and information of concern. Notifications are information about specific events the provider is required to tell us by law. The provider had also completed a Pre Inspection Record (PIR). The PIR is a form the service uses to tell us about the things they do well and the improvements they plan to make.

As part of our inspection, we spoke with four people who used the service and looked at other feedback gathered by the service such as through relative questionnaires. We spoke with three care staff and the manager.

We reviewed the care records of three people who used the service and four staff files. We looked at other documents related to the running of the service such as audits and quality monitoring documents.

Good

Is the service safe?

Our findings

Not everyone in the home was able to answer specific questions about their experiences of living in the home, due to their communication needs. However, those people who were able to speak with us told us they felt safe and happy. It was evident from our observations that people were comfortable and at ease in their surroundings.

People had risk assessments in place to guide staff in providing safe care for people in the home. We saw an example for one person where the risk assessment had been updated in response to a person's particular needs and how well they were able to manage the physical environment of the home. It was clear that thought had been given to not placing unnecessary restrictions on the person and supporting them to be as independent as possible. Staff had liaised with healthcare professionals to provide technological aids that helped the person remember to seek staff support when they used the stairs. We observed this system in use during our inspection.

We noted in some risk assessments that the language used was non-specific and did not give clear enough instruction. For example, one risk assessment stated, 'Should be encouraged to develop independence and confidence', without any further detail about how this should be achieved. However, other risk assessments contained clearer instructions for staff to follow such as reminding a person to eat slowly and cut up their food to reduce the risk of choking.

There were sufficient numbers of staff to ensure people's safety and their needs were met. During our inspection, we observed that people who required support outside the home were able to go out when they wished. Staff confirmed that this was the case. Staffing levels were flexible according to the needs of the people in the home. The manager told us that recently in response to an increase in people's needs, an extra staff member had been brought in to support people during the day. It had also been recognised by the provider that manager cover had not been working well as a part time arrangement and so the new manager had been recruited on full time hours.

When new staff were recruited to the service, checks were undertaken to ensure their suitability for their role. For the two newest members of staff in the home, we saw that a Disclosure and Barring Service (DBS) check had been carried out. A DBS check identified whether a person is barred from working with vulnerable adults and whether they have any convictions that affect their suitability for the role. References from previous employers were also sought.

People were protected because staff had received training and knew the procedures to follow if they were concerned about how people were treated or if they suspected abuse. Staff were confident in reporting any concerns to the manager and knew where to find the provider's policies if needed. A senior member of staff explained how recently they had reported a concern to the relevant authorities, demonstrating that they were able to follow correct procedures in the absence of the manager. Staff were aware of the organisations they could approach if they were concerned that the organisation was not addressing issues, such as the Care Quality Commission, police or local authority.

People received support to receive their medicines safely. Medicines were stored securely so that only staff who were authorised to do so could access them. Temperatures were taken regularly to ensure medicines were stored in the recommended conditions and remained effective. There was a system in place to monitor medicines when people needed to take them out of the home. These were signed for when removed from the home and again when they were returned. Regular stock checks were taken to ensure that stock levels were as expected. This gave opportunity for staff to identify any discrepancies or errors and ensure that people were receiving their medicines as prescribed. We checked the stock levels of two medicines and these were correct according to the home's records.

When people were given their medicines, it was recorded on a Medicines Administration Record chart (MAR). We checked a sample of these and found no omissions or errors.

Some people had medicines that were only to be given 'as required'. There were protocols in place to guide staff in how and when these medicines should be used. These described for example, the dosage required, when they should be administered and when further medical help should be sought, if the medicine was not effective.

There was a system for recording any accidents and incidents that occurred in the home. The manager reviewed each form before they were sent to a central office for the organisation to record. This gave opportunity for any trends in the types of accidents occurring to be acted upon to prevent reoccurrence. It was clear that where concerns were identified about a person through incident and accident monitoring then action was taken to address the risk.

Requires Improvement

Is the service effective?

Our findings

The manager told us that when they had arrived in post, they had identified staff supervision as an area of concern. This had been addressed immediately by the manager. All staff had received a supervision session in the time that the new manager had been in post. Prior to this, there were significant gaps between supervision sessions. Supervision is an opportunity for staff to discuss their performance and development needs with their line manager or another senior member of staff and helps ensure that staff have the skills and training to carry out their role effectively. It was also evident that not all staff had received an annual performance and development review (PDR). This is a meeting that takes place annually to discuss a member of staff's performance over the year and identify expectations for the following year. It was clear from the manager's records that they had identified that PDR meetings needed to be arranged and were in the process of arranging this.

There were only two members of staff who had been recruited recently. These two members of staff had not completed the Care Certificate. The Care Certificate is a programme of induction that covers the basic standards that all care staff should reach. The area manager told us that the staff concerned had originally begun working at the home on a fixed term contract and there had been some uncertainty about long term funding for the posts. This had led to delays in completing the Care Certificate. However, it was agreed that it should have been done. The manager had made arrangements for the induction and support of these staff since arriving in post; prior to this there was a period of time when the staff had not received an adequate induction and support.

There were records in place to record what training staff had received and we saw that this included safeguarding vulnerable adults, health and safety, moving and handling and equality and diversity. We did note that a number of staff had not received training in the Mental Capacity Act 2005 (MCA), or required refresher training. However, the manager showed us a meeting agenda, which showed that the MCA was going to be discussed at the next team meeting. The manager also told us the MCA was discussed informally on a regular basis with staff in relation to the people they support. It was evident from our discussion with staff that they understood the principles of the legislation. For example, staff told us "People should be assumed to have capacity unless it can be proven otherwise". Staff also understood the process of making decisions in a person's best interests if they lacked capacity to make the decision independently.

There was a clear statement in each person's file about their capacity to make decisions. For example, some people were able to make day to day decisions but needed support for more complex decisions.

There were records in place to show that capacity assessments and best interests decisions had been made for people as necessary. These were in place for example in relation to issues such as the administration of medicine. We did find in one instance however, that a capacity assessment had not taken place for one person who had recently had a sensor mat put in place in their room. This was in place for the person's safety so that staff were alerted and able to ensure the risk of the person falling down stairs was reduced. Although a capacity assessment and best interest decision had not been documented, it was clear that the manager had given thought to the best option for the person; they told us that they were considering using a

door sensor instead of sensor mat. This would reduce the potential impact on the person's privacy by only alerting staff if the person left their room, rather than each time they moved from their bed. This would still enable staff to manage the risk of the person falling on stairs outside of their room whilst also ensuring it was the least restrictive option.

Some people in the home had a DoLS authorisation in place. For two of the authorisations we viewed there were conditions placed on the authorisation. For example, to ensure that monthly contact was made with the person's paid representative. A paid representative is appointed to support the person who has the DoLS in place. For the two people we checked there was no evidence in place to show that monthly contact had been maintained either through a visit to the home or via an email or phone conversation.

There was a further condition on the authorisations to ensure that care plans identified and reflected the restrictions placed on the person's care and to ensure they were reviewed monthly. For one person with this condition in place, there were care plans in their care filed dating from 2010 and it was not identified that the person had a DoLS authorisation in place.

People were supported nutritionally to ensure they ate healthily and had enough to eat and drink. The member of staff responsible for meals was knowledgeable about people's needs; for example, some people required a 'soft diet' to ensure they could eat their meals safely. The chef described how they liked to ensure that nobody felt singled out at mealtimes and so anyone who required a soft diet, where possible had the same meals as others but adapted to suit the person's needs. The chef was also aware of people for whom staff were trying to encourage to eat a more healthy diet. If the person chose an option from the menu, that was not the healthiest one on offer, the chef told us they would adapt the portion size and increase the amount of vegetables so that the person's choice was respected but it still met their needs.

We saw, at the midday meal that people were enjoying their food. Those people who required particular equipment to help them eat independently, such as plate guards had them in place. Throughout the inspection, people were able to have drinks as they wished.

There was information in place to show that people were supported by healthcare professionals when necessary. This included check-ups at the dentist and optician. The manager was in the process of updating health action plans for each person and told us through doing this had identified that for some people appointments for annual health checks were overdue. This was being addressed to ensure everyone's health appointments were up to date. There was information contained in people's care files about how they could best be supported at health appointment.

Good

Is the service caring?

Our findings

Staff were kind and caring and it was clear that there were strong relationships between staff and the people in the home. Not everyone in the home was able to communicate their needs verbally; however, we observed that staff were able to understand people's gestures and facial expressions so that communication was successful and people received reassurance when they sought it. One person expressed to staff through non-verbal means that they wanted to move rooms. The staff responded in a reassuring tone that they would be moving in two days time. The staff member explained that a room move had been arranged for this person and the person had demonstrated they were anxious to make the move, having already packed many of their belongings.

Another person preferred to communicate through writing and staff supported this. This person gave us feedback about their experiences of the home by writing down that they were happy and telling us they enjoyed playing snooker with staff. We also saw that this person had been supported to make a complaint in writing. This ensured this person's views and concerns were heard.

People were supported and encouraged to be independent where possible and changes to the environment of the home had supported this. Staff told us that a 'wet room' had been installed recently with the needs of one particular person in mind. It had also proved to work well for other people by allowing them to use the room independently and eliminating the need for a hoist. During the midday meal, people ate their meals independently and had equipment in place to support them in this, if required. People who had been assessed as safe to do so were able to access the local community independently. Care plans identified the parts of people's care routines that they were able to manage independently.

People's religious and faith needs were taken in to consideration. For example, we noted that one person was supported to attend a local church each week.

People were able to attend resident meetings if they wished to. We saw from minutes of previous meetings that people had been able to give their views and opinions about the service and raise any concerns they had. It was also clear that important information about the running of the home was shared with people living there. For example, changes in staffing. In one meeting record, it was noted that summer holidays needed to be arranged for people. It was evident that this had been actioned as people in the home told us they were looking forward to their stay at a holiday camp in the summer.

People and their families were able to attend care reviews and this gave opportunity to reflect on what goals people would like to achieve and to plan what support was necessary. Care plans were produced in a format that was supported by photographs and pictures to ensure they could be accessed by people.

People were able to maintain relationships with those people who were important to them. One person told us they were going to phone their parent that evening, and were clearly looking forward to this. People were also supported to send cards for relatives on their birthdays. We saw letters from one family expressing how pleased they were with the care provided for their relative. Care files contained details of when relatives had

been contacted to keep them informed of important information.

Requires Improvement

Is the service responsive?

Our findings

People were supported to make complaints if they wished to and these were investigated and responded to. We did discuss with the manager how it was difficult to get an overall picture of how well complaints were handled because the system for filing information about complaints was ineffective. For example, we found a copy of a complaint in a person's care file, which looked initially as if it had not been responded to. On further investigation we were shown a response to demonstrate the complaint had been investigated but that the information had not been filed in the complaints folder.

There was information about making complaints in a format suited to the needs of people in the home, on display. Staff also explained how they would use visual cues to support people to make a complaint if necessary. People confirmed with us that there was somebody they could talk to if they were concerned about anything.

We observed that all staff engaged in supporting people to take part in activities in the home and to go out if they wished to. There were activities available around the building for people to access if they wished. For example, we saw a member of staff playing pool with one person and several people were supported to go out shopping. Another person was engaged independently in a bead activity. Staff confirmed with us that people had opportunity to go out regularly if they wished to. During our inspection, one person was receiving a reflexology massage. The person was clearly enjoying this and told us it was "relaxing". We saw from the manager's action plan that they had identified the need to devise structure meaningful activity plans for all residents in order to improve people's experiences further.

People had plans in place to describe the types of support they wanted and the goals they were working towards. However, it was not clear whether these were fully reflective of people's current needs and how well people were working towards their goals. This was because plans had dates on them, in many cases 1 to 2 years old. There were brief notes to evaluate plans but it was not clear that the plans had been fully reviewed and discussed with the person on a regular basis to ensure they remained relevant. One person had an 'essential lifestyle plan' in place dated October 2015. The person's goals arising from this plan had not been evaluated since June 2016. Another person's essential lifestyle plan was dated from 2014. We also found care plans (describing people's personal care needs) dating back to 2010. We discussed this with the manager who was aware that records needed updating and had included this on their action plan for the service as a high priority.

Staff were knowledgeable about the people they supported and in many cases had worked with the people in the home for a number of years. There was a keyworker system in place. A keyworker is a member of staff with particular responsibility for the wellbeing of the person they are allocated to support. Staff told us details about people in the home such as one person being "very independent" and another person for whom routine was very important. One member of staff who had recently began working at the home as bank staff, told us they had been made aware of important information about people in the home so that they could meet their needs. For example, the member of staff described what they needed to do to manage people's health conditions outside of the home.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found that not all notifications had been made to the Care Quality Commission as is required by law. Notifications for those people with DoLS authorisations in place had not been made. Without notifications, the Care Quality Commission cannot effectively monitor how well people's rights are being met.

This was a breach of Regulation 18 4 (b) of the Care Quality Commission (registration) regulations 2009.

There was a manager at the home who had been in post for approximately a month. They were soon to follow the process to become registered manager. Prior to the manager arriving in post, there had been a part time registered manager in position. It had been recognised that the position required full time hours and the new manager had been recruited in this capacity. There was also senior team leader in post supporting the manager. The senior team leader told us they had recently been recruited to this position and received good support to take on the extra responsibilities associated with the role. The home was also supported by an area manager, who was present for part of our inspection. The area manager was confident that the new management arrangements would work well to bring improvements to the home.

It was clear that many of the shortfalls we found at inspection had already been recognised as these linked directly to the action plan produced by the new manager for the service. For example, we found that people's care plans required reviewing and updating. This was included as a high priority on the manager's action plan; the manager told us this would be addressed once health action plans had been updated. We saw evidence that health action plans had been worked on. During our inspection, we also found that staff supervision and annual performance reviews had not always been completed. This again was included in the manager's action plan. It was evident from staff files that supervision had taken place since the manager had arrived in post and this demonstrated that the manager was proactive in identifying and addressing issues with the service. The manager was open and transparent about the shortfalls they had identified and was keen to address them.

There were systems in place to monitor the safety and quality of the service provided. These were effective in identifying any concerns and driving improvement in the service. For example, the manager completed a monthly assessment, which corresponded to the five domains covered at Care Quality Commission inspections. This had identified issues that fed in to an action plan. There were also audits carried out in relation to health and safety and infection control. We did note that one of these audits was overdue to be completed again; however, the manager immediately booked a date for this to be carried out. Quality assurance systems, however had not identified that people's rights in relation to DoLS authorisations were not being fully met because conditions placed on them were not consistently adhered to.

We recommend that the quality monitoring systems in the service are reviewed to ensure that they fully monitor the rights of those people with DoLS authorisations in place.

Staff were positive about working in the home and reported they felt the team had worked well through a

number of changes in management in recent years. Key issues with the running of the service were discussed at team meetings. We viewed meeting minutes as evidence of this. We did receive some comments about the increased responsibilities associated with the role of the care worker in the home that had occurred over time, such as expectations around leading a shift and this had increased the stress on staff. Though staff did not feel that this had impacted on care delivery.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notification for people who had DoLS authorisations in place were not made to the Care Quality Commission. Regulation 18 4 (b)