Hillcrest Manor Limited

Hillcrest Manor Nursing Home

Inspection report

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Date of inspection visit: 8 September 2015
Date of publication: 18/11/2015

Ratings

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

Overall summary

The inspection was carried out on the 8 September 2015 and was unannounced.

Hillcrest Manor Nursing Home provides general nursing and specialist nursing dementia care and treatment for up to 47 adults. There were 29 people living at the home on the day of our inspection. People were cared for in two units The Granary and Manor House.

There was no registered manager in post however, the new manager started work 15 June 2015 and had submitted an application to become the registered manager of the home. They were present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We found that the provider needed to make improvements to ensure appropriate measures were put in place to ensure people were protected from harm or abuse. We saw that the provider had not reviewed the information about the outcome of a referral to the local authority safeguarding team. We therefore could not be assured that appropriate action had been taken to protect the person.

Staff did not have a full understanding about the mental capacity act (MCA) and we could not be assured that decisions that had been made were made in people's best interest.

People's dignity had not been consistently protected. We observed that people on Granary unit were not given knives and forks to eat their lunch with due to a blanket approach by staff based on the perceived risks posed by one person.

People did not always benefit from effective communication by staff. We observed that staff did not always explain to people what they were going to do with them.

Audits completed by the manager were not driving improvements because they had not identified the shortfalls that we had found and did not identify who would take action and when.

Current arrangements for monitoring staff competency and staff approach were not effective in identifying shortfalls in the quality of care people received.

People felt that staff were able to support them safely. Staff had received training in safeguarding and knew how to identify and report abuse. Staff knew how to deal with accident and incidents and there were systems in place to reduce risks.

People received appropriate support to take their medicines and there were safe systems in place for the ordering, storage and disposal of medicine. People had access to health care professionals as and when required.

People nutritional needs had been assessed and reviewed and they were given a choice of what they wanted to eat. People told us they enjoyed the food and we observed that they were given support to eat where needed.

People were spoken to in a kind and polite manner. People were supported to remain as independent as possible and could choose how they wished to spend their time. Whilst some chose to sit in the lounge and take part in activities others liked to have some private time in their rooms.

People felt the manager was friendly and approachable and that they could speak to them direct if they had any complaints or concerns. People and staff felt that they could confidently put their views on the service forward and that they would be listened to.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe

People were not sufficiently protected from harm or abuse because the provider had not followed up the outcome of all safeguarding referrals. People felt that staff supported them to move around the home safely and knew what action to take if they suffered an accident or incident.

Requires improvement

Is the service effective?
The service was not consistently effective

People's ability to make decisions about their own care and treatment had not been appropriately assessed. People enjoyed the food and had a choice of what they would like to eat. People were supported to see health care professionals when they needed to in order to maintain good health.

Requires improvement

Is the service caring?
The service was not consistently caring

People's dignity was not consistently promoted. People were able to choose how they spent their time. Staff were kind and polite to people and their relatives. People's needs and preferences were clearly recorded in their care plans and staff were aware of their likes and dislikes

Requires improvement

Is the service responsive?
The service was responsive

People were involved in writing and reviewing their care plans. Staff knew people well and were responsive to their needs and wishes.

People were supported to keep in contact with people who were important to them and encouraged to maintain their interests and hobbies. People and their families felt able to approach management should they have any complaints or concerns

Good

Is the service well-led?
The service was not consistently well-led

Current systems for monitoring the effectiveness of staff training and staff ability to meet the needs of people living at the home did not identify shortfalls in the quality of care. Quality checks were completed and actions identified however it was unclear who was responsible for completing these actions and by when. People, relatives and staff told us that the manager was approachable and listened to them

Requires improvement

Hillcrest Manor Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 September 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We used this information to plan the inspection.

During the inspection we spoke with four people who lived at the home and three relatives. We spoke with twelve staff which included the manager, the deputy manager, one nurse, six care staff, three domestic staff. We viewed seven records which related people's medicines, assessment of needs and risks and consent. We also viewed other records which related to management of the home such as complaints, accidents and recruitment records.

We spent time observing interactions between people and staff and how people spent their time. We were unable to speak with some people and therefore used the Short Observational Framework for Inspection (SOFI) to help us understand their experience of the support they received.

Requires improvement

Is the service safe?

Our findings

We looked at information we held about the service prior to our inspection. There had been five referrals made to the local authority safeguarding department since April 2015. The outcome of the safeguarding investigations resulted in a temporary suspensions on new admissions whilst the provider worked with the local authority to improve the quality of the service. The provider was now accepting new admissions. We saw that the provider had made relevant referrals to the local authority safeguarding team who were responsible for reviewing incidents of abuse. However when we looked at one person's care record we could not find the outcome of a visit by the social worker in relation to a safeguarding incident that had occurred. When we spoke with staff they were unaware of the outcome of the social worker's visit and had not followed up the outcome of the safeguarding referral. Therefore a new care plan completed for the person did not contain all the relevant information about the person's needs and we could not be assured that appropriate measures had been put in place to protect this person. When we spoke to the manager they were unaware that relevant information had not been included in the person's care plan and agreed to review the person's needs.

People told us how they felt safe when staff supported them to use equipment to move around the home. One person explained how staff transferred them to an armchair in the lounge. They felt staff did this safely. We saw that staff employed the correct equipment and support to enable people to move around the home safely. We saw that risks to people's safety had been routinely assessed, managed and reviewed. Care records included a variety of assessed risks such as nutrition and mobility. Staff were able to tell us what support people required to promote their safety. Staff had completed training on safeguarding and showed a good understanding of what constituted abuse and what action they would take if they witnessed or became aware of any abuse taking place. People and their relatives told us they felt able to report any concerns they had to the staff or management

Staff we spoke with demonstrated a clear understanding of how to manage accidents and incidents. It was the nurse in charge's responsibility to complete the forms and notify people's families. The manager told us they analysed the incidents and identified if there were any risks to the people. Details of how risks could be minimised were recorded. Where individuals had repeated falls appropriate professionals were involved to check if their health needs had changed or additional equipment was required.

People told us they thought there were enough staff on duty. People had a call bell to alert staff if they required any assistance. During our visit we saw people received care and support in a timely manner and were not rushed. The manager told us staffing numbers were determined according to need and they were regularly reviewed. Staffing levels could be adjusted to respond to changing situations, for example, if people became particularly unwell. The manager told us they had been using agency staff to cover shifts but had been recruiting continuously to fill permanent vacancies. The provider's recruitment process ensured staff were suitable and safe to work in a care environment. These included references and checks to ensure staff had the specialist skills, qualifications and knowledge required to provide the care to meet people's needs.

People told us that staff supported them to take their medicines as prescribed. People's preferred way of taking medicines was recorded on their medicine record. We observed that staff supported people to take their medicine in a kind and reassuring manner. There were robust systems in place for storing, ordering and disposing of medicines. Only staff who had received medicine training administered medicines and received regular competency checks to ensure the safe management of medicines

Requires improvement

Is the service effective?

Our findings

The provider had not consistently followed the principles of the Mental Capacity Act 2005 (MCA) and MCA code of practice. Whilst the provider had completed capacity assessments and best interest decisions for some people in relation to their day to day care, they had failed to prove that people had not got the capacity to make other important decisions. For example the provider had submitted deprivation of liberty safeguards (DoLS) application for the majority of people living at the home but they had not assessed people's capacity to make decisions in relation to the deprivation. We also observed that a relative had signed a 'consent to all care' form on behalf of a person without the provider completing a MCA assessment to prove that the person was not able to make this decision themselves. We therefore could not be assured that people's human rights were protected or that decisions made on their behalf had been made in their best interests. When we spoke with the manager and staff we found that they did not have a full understanding of their responsibilities under MCA.

Staff were able to demonstrate their understanding of people's general needs and how they used this knowledge to enable people to make their own decisions about their daily lives wherever possible. Staff spoke of their understanding of verbal and non-verbal consent and for people who were unable to give consent because they lacked capacity to do so. We observed people's care records that these issues were regularly reviewed and updated, for example, a decision to not perform resuscitation on a person was fully recorded.

Staff told us there were opportunities for on-going training and for obtaining additional qualifications. There was a programme to make sure staff received relevant training and refresher training was kept up to date. Staff confirmed they had completed an induction programme when they commenced employment. They worked alongside more experienced member of staff until they were confident in their role. Staff told us they felt supported by the manager and senior staff. They told us they had received individual supervisions where they were able to discuss their training and development needs.

People told us that they got to see health care professionals such as the doctor and chiropodist when they needed to. This was confirmed in people's care records. For example, the staff worked with the tissue viability nurses to identify people who were at risk of pressure damage to their skin. Where people were assessed as being at risk, records showed that pressure relieving equipment was in place and they were being seen regularly by the nursing team. We also found the staff worked closely with the community mental health team to help them support people living with dementia.

People told us that the food was very nice and that they could make requests for something different to the menu. One person told us they did not like either choice on the menu on the day of our inspection and that the cook was going to make them something they liked instead. Relatives told us the food was very good one said "The food is all homemade, you can tell that". People were supported to eat and drink sufficient amounts and told us they enjoyed the food. Staff monitored people's weight and took action if there were any issues. One relative told us that there had been concerns about their relative's weight loss and staff had managed to get them to eat and drink more and they had gained weight. We saw that each person had their nutritional needs assessed and reviewed. Staff monitored people's food intake and recorded this. Records showed staff supported people to have as balanced a diet as possible and maintain a stable weight. At lunch time we observed that staff were on hand to assist people as needed.

Requires improvement

Is the service caring?

Our findings

We observed that people's dignity was not consistently protected. At lunchtime on Granary unit we saw that all eight people living on the unit were only given a dessert spoon to eat with. When we spoke with staff and asked them why people were not given knives and forks to eat with, they told us this was due to the needs of one person who they considered to pose a risk if they were given a knife and fork. This demonstrated a blanket approach by staff that showed no regard for the other people's dignity and individuality.

We saw that staff did not always communicate effectively with people. When staff assisted some people they did not always explain what they were going to do. For example, in the Granary unit staff put clothes protectors on people at lunchtime to protect their clothes without asking or explaining what they were doing. Drinks were put on the table without giving people a choice or telling them it was there for them. In Manor House staff moved tables up to people to eat their lunch off without asking them where they wished to eat or explaining what was happening.

When we spoke with the manager they were not aware of the practice we had witnessed and agreed that this did not reflect a person centred approach. They agreed to review current practice and arrange training and support to enable staff to meet the needs of people living at the home.

People and their relatives told us they were involved in decisions about their care and staff kept relatives informed about changes in people's needs. Staff we spoke with told us they involved people and their families in their care planning and respected that everyone's needs were different. We saw that care plans recorded people's choice and preferred routines for assistance with their personal care and daily living.

People told us that staff were kind and polite. One person said, "I have a natter with them, I have a laugh with them". One relative said, "They are all very polite, haven't met anyone who hasn't been". People told us they were able to make choices about their day to day lives. People said they chose what time they got up, when they went to bed and how they spent their day. They felt listened to, one person said, "You say whether you like something or not" and staff would respect their wishes.

Staff were positive about their caring role and talked fondly of people they supported. One staff told us how liked to sit and talk with the people and do a bit of singing with them

Good

Is the service responsive?

Our findings

People and their relatives told us they were involved in planning their care right from the beginning. The provider had assessed people's needs prior to them moving into the home to ensure the service was able to meet their needs and expectations. Where people lacked capacity to make decisions for themselves family members confirmed that they had been involved in writing and reviewing their care plans. One relative told us that staff had put a good care plan in place for their relative and felt that they received a high level of care. We saw that care plans were personalised to the individual and gave clear details about each person's specific needs. Staff demonstrated that they knew people well as they were able to tell us information about different people's needs and the support they required. Staff told us how some people could become anxious or distressed and how they would respond to different people's needs in order to manage their anxieties. We observed that one staff member used distraction techniques to reduce a person's anxiety with a positive effect.

People told us they could choose how they wished to spend their time. One person said, "They [Staff] just ask what you want to do". Another person told us they were happy to sit in the lounge all day and staff would sit and talk with them when they got a chance. Staff told us that when people first moved in they sat and talked to them and their relatives to get to know about their past such as where they worked, what their interests were and about what was important to them. We saw that people were supported to keep in contact with people who were important to them and to maintain involvement in their particular interests. We observed staff supporting a person to read through mail they had received that day. The activity person told us that they were continually looking at how they could support a people's individuality and enable them to participate in activities that were meaningful. They got memory bags from the local library and used them to do reminiscence work such as making tea. We observed the activity person spent one-to-one time with individuals and assisted people with their requests of social pastimes.

People and their relatives told us they had been given information about how to complain and felt able to raise concerns with staff or management. We saw that details of the complaints procedure were displayed in the home however this needed to be updated. We discussed this with the manager who agreed to make the necessary changes. We also saw that there was a suggestion box in the hallway to encourage people and their relatives to make comments about how the service could be improved. We observed that the provider had recently received one complaint, they had recorded the detail of the complaint and the action they had taken to address the issues raised..

Requires improvement

Is the service well-led?

Our findings

The manager had started working at the home as relief manager on 15 June 2015 and was in the process of applying to become the registered manager. The manager told us when they first took up their post they had needed to concentrate on the management of the service in particular recruiting permanent staff to vacant posts. The manager had also implemented daily meetings with the head of each department in order to share issues and decide a way forward. They stated that they had been unable to spend as much time as they would have liked out on the units. A 'dignity in care audit' was completed in July 2015 and looked at policies, culture, environment, communication and meal times no issues had been identified at this time. The manager was not aware of the shortfalls we identified during our visit. They acknowledged that work needed to be done to ensure that staff received appropriate training and support to enable them to meet the needs of people living at the home. The manager took immediate action to source training on the MCA and agreed to source additional training in regard to dementia and effective communication. It was the stated intention of the manager to work alongside staff to assist and monitor the quality of the care provided. The manager told us that if they had any concerns about individual staff's practice they would address them through additional supervision and training.

The provider or registered manager is required by law to notify the Care Quality Commission (CQC) of certain events, these are called statutory notifications. Whilst the provider had notified CQC of some of the safeguarding referrals they had made to the local authority they had not told us about the latest safeguarding referral they had made. The current manager was not aware that the statutory notification had not been sent to CQC as the incident occurred before they had started to work for the provider. They were however aware of the procedure that should have been followed and agreed to ensure all staff were aware of the process.

We observed that the manager conducted audits of the service, for example, health and safety, infection control and medicines management. We saw outcomes of these audits were recorded however action plans developed did not identify who was responsible for completing the actions and by when. When we spoke with the manager they agreed to review the systems they had in place to ensure that their quality systems were driving improvements in the service.

People told us the manager was very approachable and regularly asked them for their views of living in the home. This was a view shared by people's relatives, one relative said "Every time I have come in they [Manager] have spoken with me. They make the time to speak to me". Another relative told us that the manager regularly told them to approach them if they wanted anything.

The manager told us they wanted to provide good care that treated people as individuals. Staff described the service as caring and told us that morale was good. There was a positive culture within the staff team with an emphasis on making people's daily lives as pleasurable as possible. Staff said they were supported by the manager and deputy manager and were aware of their responsibility to share any concerns about the care provided at the home. Staff told us they were encouraged to make suggestions regarding how improvements could be made to the quality of care and support offered to people. We observed minutes of meetings which confirmed the discussions.

There was a management structure in the home which provided clear lines of responsibility and accountability. A manager was in post who had overall responsibility for the home. They were supported by a deputy manager, nurses and senior team leaders. Staff said there was always a more senior person available for advice and support. The provider visited the home regularly to monitor the quality of the service by speaking with people and staff. The manager told us the provider maintained a broad overview of the home and that they spoke or met with them regularly and they supported them in their role and made funds available for any repairs and re-decorating as needed.

The provider gave out questionnaires annually to people and their families to ask for their views of the service. The latest survey was in the process of being collated and therefore we are unable to report on the outcome.