Harbour Healthcare Ltd

Hilltop Hall Nursing Home

Inspection report

Dodge Hill
Heaton Norris
Stockport
Cheshire
SK4 1RD

Tel: 01614803634
Website: www.harbourhealthcare.co.uk

Date of inspection visit:
31 October 2017
01 November 2017

Date of publication:
28 December 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 31 October and 1 November 2017.

Hilltop Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

We last carried out a comprehensive inspection on 31 August and 1 September 2016. At this inspection we found the service to be in breach of the regulations relating to the management of medicines, recruitment practices, arrangements for the assessment of nursing residents prior to admission, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS), staff training and quality assurance.

We returned to the service to carry out a focussed follow up inspection on 25 April 2017. Although we saw improvements had been made to arrangements for the assessment of residents in need of nursing care prior to admission, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) and staff training there were continuing breaches of medicines management, recruitment procedures and the management of the service. There was no registered manager in place at either of the above inspections and we were also concerned about the levels of agency staff being used at the home. The overall rating of the service was requires improvement.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions is the service safe and well led to at least good. At this inspection, we found that improvements had been made in all areas and plans were in place to make further improvements.

Hilltop Hall Nursing Home is situated close to Stockport town centre. The home provides nursing and personal care for up to 54 people. At the time of our inspection, 46 people were living at the home.

People who used the service had a diverse and wide age range of nursing and personal care needs. These included older people with age related health conditions, younger people with physical needs such as amputations and Multiple Sclerosis as well younger people who had a learning disability and/or mental health needs that may be challenging to others.

The service had a registered manager in place. The manager was registered with us on 17 August 2017 and had worked at the service since April 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present during most of this inspection.

At this inspection, we found that improvements had been made in relation to safe management of medicines and recruitment procedures. The numbers of agency staff being used by the service had significantly reduced.

The registered manager and deputy manager with support from the quality manager were more effectively managing the day-to-day operations of the service. The management team's priority had been to reduce the use of agency staff and build a strong confident staff team to help provide consistent and safe care to people.

Staff had received training in safeguarding adults. Staff were confident that action would be taken by managers if they reported any abuse they witnessed or suspected.

Risk assessments were in place in relation to the environment and for people who used the service.

We found the home to be clean and tidy throughout and systems were in place to help control and protect people from infection.

The premises were spacious, well maintained and furnished to a good standard.

People gave mixed responses about the food provided. Plans were in place to improve the menu. We saw that people were offered a choice of food and were encouraged by staff to eat as much as possible.

People had access to a wide range of healthcare professionals who understood their needs.

The atmosphere at the home was relaxed and calm. Interactions between people who used the service and staff were seen to be warm, frequent and friendly.

Improvements had been made to people's care records; however records were still being closely monitored by managers in line with quality assurance procedures. This was to ensure consistency and good practice was being sustained.

We saw that there were activities for people to join in. We were told that there were plans in place to further improve activities to include people going to activities outside the home and for people with dementia.

The service had a complaints policy and procedure in place.

The service had a manager in place who was registered with us and a deputy manager who were working hard to make improvements at the home. Staff spoke positively about working at the home.

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.

Improvements had been made to ensure the safe management of medicines.

Recruitment procedures had improved and there was less reliance on agency staff throughout the day.

Staff had received training in safeguarding adults. There were systems in place to help ensure staff were supported to report any abuse they witnessed or suspected.

Systems were in place to help prevent the risk of a spread of infection.

Is the service effective?

Good

The service was effective.

Staff received the induction, training and support they needed to be able to provide safe and effective care.

The registered manager had taken appropriate action to apply for legal restrictions to be put in place, if in a person's best interests.

People were supported to maintain good physical and mental health through regular monitoring in the service and attendance at external appointments.

Is the service caring?

Good

The service was caring.

The atmosphere was relaxed and calm.

We saw frequent and friendly interactions between people who use the service and the staff supporting them.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's support needs and personal preferences.

Activities were taking place. We saw a new activities co-ordinator was in post and a second activities co-ordinator was to be employed to help ensure further improvements particularly for people who lived with dementia.

Systems were in place to enable people to make a complaint.

Is the service well-led?

Good

The service was well led.

The service had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

A deputy manager, who was also the clinical lead, supported the registered manager. Both demonstrated a commitment to making continuous improvements at the home.

Staff told us that they thought the management of the home had improved and this had had a positive effect on morale.

Hilltop Hall 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 was an unannounced inspection and was undertaken by two adult social care inspectors.

Prior to our inspection, we contacted the local authority and clinical commissioning group (CCG) safeguarding and commissioning teams. We received information back from the local authority safeguarding manager and the quality assurance officer who carried out monitoring visits to the home. This information helps us to get a balanced view of the service.

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. We used this information to inform our inspection. We also reviewed the information we held about the service including the last two inspection reports and notifications the provider had made to us.

During the inspection, we spoke with four people who used the service and three visitors. We also spoke with the registered manager, the deputy manager, a quality assurance manager, the managing director, the care quality lead, a permanent and agency carer on nights, a nurse on days, one senior carer and four care staff.

We looked around most parts of the home and spent time observing how people were cared for. We also looked at a range of records relating to how the service was managed; these included medication records, staff personnel files, staff training records and health and safety audits.

During our inspection, we carried out observations in public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At the last focussed follow up inspection on 25 April 2017, we found that the home was in continuing breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the safe management of medicines. The overall rating for this key question was requires improvement.

Following the last inspection we asked the provider to complete an improvement action plan to show what they would do and by when to improve the key questions to at least good.

At this inspection we saw that medicines were kept in locked medicine trollies within locked treatment rooms. There was a clear process for handing over keys for medicines from shift to shift and this was recorded on the staff handover sheet. This meant that only authorised staff would have access to the treatment rooms.

Some prescription medicines are called controlled drugs and are subject to stricter controls to prevent them being misused or obtained illegally. We saw that controlled drugs were stored separately in a locked medicines cabinet. There was a controlled drugs register in use which was signed by the staff member administering the drug and also a witness. We reviewed the audits of the stock levels of controlled drugs and these had been signed by two staff members. We checked the remaining stock of five of the controlled drugs and saw these matched the records held in the control drug register.

If medicines are not stored at the correct temperature they may become less effective or unsafe to use. The medicine rooms contained suitable lockable fridges and air conditioning and fans had been put in place to help prevent the rooms getting too hot. The temperature of both the fridges and the medicine rooms had been recorded daily and were within the acceptable ranges. This meant the medicines were being stored and managed in a safe way.

People's medication was stored in a separate monitored dose system (MDS) with their name, room number and a photograph to help identify the person and ensure they received their medicines correctly. Some medicines, such as eye drops, needed to be used within a certain time after being opened to ensure they are effective. Where medicines had been opened the date of opening had been clearly marked on the label and all the medicines we saw were in date.

We saw staff administering medicines. They wore red 'do not disturb' tabards and gave people gentle encouragement to take their medicines without rushing them. We saw that were a person had a learning disability staff used picture format faces that help the person to indicate the level of pain they were in. We also saw that were a person was self-administering their inhalers a risk assessment was in place, allergic reaction to medication risk assessment, and risk of seizures.

At the last focussed follow up inspection on 25 April 2017, we found that the home was in continuing breach of Regulation 19, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons. The overall rating for this key question was requires improvement. This was because we

found a person had been working with a Disclosure and Barring Service (DBS) Adult First Check but without a risk assessment in place until the full disclosure from DBS was received. A check with DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The overall rating for this key question was requires improvement.

Following the last inspection we asked the provider to complete an improvement action plan to show what they would do and by when to improve the key questions to at least good.

Staff we asked confirmed that all the recruitment checks had been done before they started work at the service. The agency worker confirmed that the agency carried out recruitment checks.

At this inspection, we reviewed five staff personnel files of people who had been recruited since our last inspection. We found the recruitment process had been robust and people had the full disclosure from DBS before starting work. A full employment history had been recorded and references from appropriate people received. Where the file related to a nurse, a check had been made of the nurse's registration with the Nursing and Midwifery Council, the regulatory body for nurses and midwives in the UK.

A person who used the service said, "You can't build relationships with agency staff.2 A relative said they were concerned about the use of agency staff at night because they did not know their relative and their needs.

We spoke with the deputy manager who was the clinical lead nurse for the service. They told us, "We want to recruit the right people rather than just a body. We have worked hard to reduce the number of agency staff." Staff confirmed that there were no agency being used during the day shift at the time of our inspection. Plans were in place to recruit permanent staff to work during the night. A night manager was also in place to increase management oversight during the night.

We spoke to an agency night staff worker. They told us that they always worked alongside permanent night staff. They said they had worked at the home since February 2017 and had received two weeks induction training from the service which had included how to use equipment and also shadowed for two shifts with established staff. They said, "[Staff] are welcoming here and show you what to do. I work in places, which aren't like this. People come first."

Since the last inspection, the number of staff employed by the home had risen which meant there were no agency staff on duty during the day and only regular agency staff who were experienced in the home worked at night. This meant that people who used the service knew the staff and that staff were familiar with the procedures within the service. This had reduced the risk of incidents happening and mistakes being made. We were told that interviews to recruit a nurse for the night shift were arranged and once someone had been appointed it was expected no agency staff would be needed.

The registered manager had reduced the number of care agencies used from three to one. Some agency staff had come to work at the home on a permanent basis.

We were told that staffing had increased and a nurse and a senior carer were on each floor plus five care staff downstairs and three upstairs. We spoke to a member of the night staff who told us, "We have enough staff on at nights. We don't have to rush people, they may be in bed but awake so we will sit and talk or offer them drinks. Some people get lonely in the night so we talk to them."

We saw that when staff had left, exit interviews were being held by an external manager to the home to identify the reasons the staff member had left. These were then discussed with the regional manager and the registered manager of the home. The exit interviews helped to look for patterns and trends as to why staff had left and if improvements could be made to stop this happening to help build a strong and effective staff team.

The agency staff member on nights confirmed that they felt safe and comfortable to work at the home. Staff had received training in safeguarding adults. They were able to tell us of the action they would take to protect people who used the service from the risk of abuse. They told us they would also be confident to use the whistleblowing procedure in the service to report any poor practice they might observe. They told us they were certain the registered manager and deputy manager would take any concerns seriously. They said, "The managers would definitely deal with it they are both caring people and I would trust them to do the right thing" and "They would do something about it, no doubt, 100% sure. They listen, you can go to them and they would reassure you."

During our inspection, the registered manager told us about a disclosure that had been made to them. They told us that they had contacted the local authority safeguarding team about this matter. This disclosure was under investigation. We did not look in detail at the information so as not to compromise the investigation.

We looked around the home. We found that it was clean and tidy and clutter free with no malodours detected. We saw that the provider had an infection control policy and procedures. These gave staff guidance on preventing, detecting and controlling the spread of infection. They also provided guidance for staff on effective hand washing and use of personal protective equipment (PPE) such as disposable gloves and aprons, which we saw had been provided. Paper towels and hand wash were seen to be available for people to use in bathrooms and toilets. Hand sanitizers were seen to be in place throughout the home and available for people to use.

We visited the laundry, which was sited at Hilltop Court Nursing Home on the same site. We saw that the home had new digital washing machines that had sluice facilities to wash soiled items at high temperatures. Red dissolvable bags were used to transfer these items to help prevent the spread of infection. This system could also use detergents that could kill bacteria at lower temperatures to reduce the risk of damaging people's clothes. We saw a chute was used from outside the home for the dirty linen washing bags from both homes to separate dirty washing from clean.

The deputy manager told us that they had all the equipment they needed to support people. They told us that there were waiting for a bariatric (plus size) bed to be delivered so that they could admit a person to the home that needed it.

The deputy manager told us that an external moving and handling company carried out moving and handling people training. We saw that a thorough examination of lifting equipment had been carried out in September 2017, which included a bi-annual sling thorough examination report. We saw that people who used hoists now had their own slings. These were kept on a board to separate them to help prevent the spread of infection. The home had a stretcher passenger lift. We were informed that the lift had a thorough examination on 12 October 2017. We saw that footplates on wheelchairs were always used by staff to prevent injuries to people's feet when in use.

We looked at the printed version of care records for six people who used the service who had different care and support needs. We saw that risk management plans were in place to guide staff on the action to take to mitigate the identified risks. Risk assessments had been completed for mobilisation and falls, oral health

care, continence, malnutrition and dehydration risk and pressure area care. We also saw person specific risk assessments were in place, for example, behaviour and aggression, going outside for a cigarette and leaving the building.

We saw that the service produced and evacuation register often known as a personal emergency evacuation plan (PEEP). We saw this gave information to the emergency services about what support people would need to evacuate the building. Reference to emergency evacuation was also made to in people's safety and well-being care plan, for example, verbal guidance needed during an emergency, as they may not know where the fire exits are. We saw evacuation chairs were available outside the doors onto stairwells, which could be used to move people to safety.

We saw that risk assessments were in place for the environment, which included a risk assessment for the new alarm system. This alarm system had been introduced as a result of feedback from the Coroner following an incident at another of the registered provider's services.

The home had a dedicated maintenance person who performs a variety of regular checks to ensure equipment was in good condition and safe to use, which included checking profiling beds and wheelchairs. They also checked the fire and hot water systems. These checks were clearly recorded and were discussed in a monthly meeting with the registered manager where any issues were discussed and the manager signs off the checks. The maintenance person was also the fire lead champion for the home.

We were informed by the registered provider that they had a valid gas safety certificate and that the fire alarm system including the panel, emergency lighting and fire extinguishers had been checked in March 2017.

Good

Is the service effective?

Our findings

Staff told us they received the training and support they needed to be able to carry out their roles effectively. We spoke to care staff who said they felt supported. They told us, "The manager is always free to speak to. [Registered manager] sometimes pops in on the night shift to see how we are" and "We now have a brilliant staff team who can be open and honest with each other. I love the job and love coming to work. We get on with it and help each other."

The deputy manager told us that the management team were nurturing the care staff and assessing their potential for further development so that staff could take on more responsibility. They deputy manager said, "We have spent time on building the confidence of the staff. With continuity of staff we can build quality into the service."

We were told new care staff underwent a 12 week induction programme where their competency for the job was assessed by a senior member of staff. We reviewed the induction programme for the new care workers. The inductions had been fully signed off as complete. This helped to ensure that staff were competent to look after the people who used the service. Staff said, "I shadowed [senior carer] she's brilliant at her job."

The staff team training record showed that staff completed a range of online training. This training included, fire safety, first aid, infection control and COHSS hydration and nutrition including special diets, safe food handling, safeguarding and mental capacity act (MCA) and deprivation of liberty safeguards (DoLS), dementia everyday care and night time care effective written documentation. We saw that staff had completed the majority of this training and where not, records indicated that staff were on long-term sick or maternity leave.

The deputy manager told us that some staff had attended a face to face course on delivering personal care. This helped to increase their personal awareness of their own behaviours and language and how this might be perceived by others.

During our inspection, we spoke to an external training assessor who told us, "There are a lot of staff doing courses here, the management are supporting them through them. They are really supportive." Records showed that of the 32 care staff 15 held an NVQ or QFC level 2 or three in health and social care with six staff currently undertaking the courses. Plans were in place for nurses to undertake Level 5 training in leadership and management.

We also spoke with the care quality lead. They told us that The Lodge had recently become the registered providers head office and a training room had been created for staff from the three homes in the Stockport area to use. They confirmed that staff received face to face moving and handling and first aid training. Other training was online and there were plans in place for the online service to become more interactive in the near future. The care quality lead confirmed that regular agency workers also received induction training.

Supervision records showed that most staff had undertaken a one to one supervision with the registered

manager with the majority of staff receiving supervision in May and October 2017. Records showed that some staff had started to receive an annual appraisal. The deputy manager told us that they thought they had a good team of nurses in place and was confident in their abilities. The deputy manager provided the nurses with clinical supervision.

Supervision and appraisal sessions give staff the opportunity to raise any concerns they have, share ideas to improve the service and appraise the staff members competence.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. People had been assessed in line with the MCA to determine whether a DoLS authorisation was required.

Applications had been submitted to the relevant local authorities where appropriate and a record of this was kept. However we noted from the record that of the 25 applications made only seven had been authorised. This was because the local authority had triaged the applications as low priority. We saw that mental capacity was considered in all parts of the care planning process.

People we spoke with gave a mixed response about the meals they received. A person who used the service said, "Instead of having what I fancy you have to have what everyone else is having." Relatives told us, "[Relative] enjoys the food. Sometimes [relative] isn't in the mood for it and the staff don't force it on [relative] and will find something else" and "They prompt [my relative] to remind them to eat and drink throughout the day as they forget."

Meals for the home are prepared in the neighbouring care home Hilltop Court. Food preferences were identified at the time of a person moving in. The chef told us, "We found that the residents didn't like some meals so we have re-done the menu. We are inviting the residents and their families to a tasting session to get their views of the new menu before we launch it." We saw numerous posters around the home advertising the tasting session taking place on 15 November 2017.

Food was available for people outside of mealtimes. The home has a dedicated fridge, which was stocked daily with snacks, yoghurts and teacakes. We saw fresh bread and jams available in the dining room for the staff to make toast for people. The registered manager told us some people had said they would like an earlier breakfast so they had changed the shift pattern. Two care staff now started their shift earlier so that this could be accommodated.

We saw that were people needed to be assisted to eat staff sat with the person so they were on eye level, promoted independence whenever possible and encouraged them to eat as much as possible. We saw that special drinking cups and plate guards were also used to promote independence.

The chef was aware of people's needs and understood the importance of ensuring people received the food

they required. For example, people who had swallowing difficulties and were at risk of choking had pureed or fork mash able food depending on the needs assessment. Some people with dementia who were constantly on the move had fortified meals, for example, added double cream and milkshakes to boost their calorie intake and reduce the risk of weight loss. Where people who lived with dementia could still use their fingers to eat but could no longer use cutlery main meals were put on to sandwiches. This helped to promote their independence whilst helping to maintain good nutritional intake. In people's rooms we saw they had access to drinks of water or juice.

We looked at the dietary needs care plan and choking risk assessment in place for one person who had capacity and had declined to have thickener in their fluids against the Speech and Language Therapist advice and was therefore at high risk of choking. The dietary needs care plan identified the risk and to observe signs of aspiration. The person's food preferences, likes and dislikes were noted on the care plan. There was a dietary needs care plan which recommended a fluid intake and what the person liked to eat. On the service improvement plan we saw that the regional manager had kept the monitoring of food and fluid records as an amber rating until sustainability could be ensured in record keeping.

People who used the service had the same doctor who visited the home every week. A list of people wanting to see the doctor was sent to the surgery before their visit but they would see extra people on the day if people wanted to see them. The doctor also reviewed people's medicines as required. Records we saw made reference to medical notes received from the doctor. We saw that there were wound management plans in place and a chronic obstructive pulmonary disease (COPD) and lung cancer care plan. The service also worked with Mastercall. Mastercall provides out of hospital healthcare particularly for supporting people who have infections to reduce admissions into hospital.

We saw on the care records of a person who had a learning disability that they had contact with healthcare professionals from the local community learning disability team. This included the liaison nurse, community nurse, learning disability psychiatrist. They also had a health passport.

The deputy manager said that they thought they had a good relationship with the doctor and other health care professionals who came to visit people at the home. There had been one issue of concern with the district nurse team refusing to take blood samples and change dressings for none nursing residents. This issue had been referred to safeguarding.

We spoke to some people who had rooms in the old part of the property. They told us they really liked their rooms, particularly the large windows that looked out onto trees and the garden area, and could see Stockport in the distance beyond. One person said, "I can see foxes and other wildlife from my bedroom at night." Another said, "I have a lovely room and window. I keep my curtains open so I can see the trees."

We spent time looking round parts of the building. We saw that the home was well-maintained. There was a seating area to the front of the home which people could use. The quality lead for the service showed us an example of new garden furniture that would be put in place in the Spring. We saw that the main doors were open for part of the afternoon and people sat near the doors chatting and enjoying the fresh air. This area was well supervised by staff however care needed to be taken to ensure that no-one left the building or fell using the steps.

Good

Is the service caring?

Our findings

People who told us, "Staff are very caring. You can have a laugh with them, it's first name terms", "From day one I have been made to feel welcome and I have a laugh with them. The [staff] are brilliant and I'd be lost without them", "I get on great with all the staff", "[Deputy manager] has always got a smile for you. She cheers you up", "I know you see bad stuff on the telly but it doesn't happen here" and "My [relative] is no pushover but she's happy with it here."

We spoke with relatives of people who used the service. They told us, "The staff work well together. They treat the residents with respect, decency and courtesy", "The staff are great, they make me feel so welcome and comfortable whenever I come here. [My relative] has never looked better, she's on form and she's smiling", "The place is great, I can come and go when I please when I visit. If I want a cup of tea staff will make me one" and "They know [my relative] and treat them as a person rather than just a person with their condition."

When we arrived at the home we were made to feel welcome by the staff on duty. We observed a relaxed pace and very few people were up and dressed when we arrived. We saw there was no pressure to get people up and some people were still having breakfast at 10.30am.

We observed interactions between people who used the service and staff. We saw people were treated with respect and kindness. We saw that people were nicely dressed and their hair had been brushed. We saw one person being assisted from a wheelchair into a lounge chair. Staff made the transfer fun whilst keeping the person safe. We saw one member of staff was able to speak to a person with limited communication in their first language.

We saw that when staff went to support a person nursed in bed they made sure that the door to their room was closed and gave the person privacy before completing the task.

We saw that were people were nursed in bed they were in clean bedding and appeared comfortable and cosy. One person who was nursed in bed told us, "Staff are very good and cheerful even when they are doing [personal care] jobs. As long as I am comfortable, clean and well fed I am happy." People's bedrooms were personalised to their individual tastes, with televisions, music equipment, pictures, ornaments and one person had two budgies. A relative told us that they thought the presentation of people's rooms had improved recently. The dignity champion told us that it was their responsibility to check that rooms were presentable and there was attention to detail.

We were informed that two people were on end of life care. However, one person had been on a plan for a significant period of time as their health fluctuated. The deputy manager told us that they used both the Gold Standard Framework (GSF) and Six Steps programme to support people who were nearing the end of their life. We saw that there were death and dying care plans in place on people's files. Some people chose not to discuss this issue where as other people had clear plans. For example, a person with full capacity had stated that they would prefer to stay at Hilltop Hall rather than go into hospital with direction to staff to

respect the person's end of life wishes and ensure that family were by person's side and wanting the family not to be worried as they would be pain free. Another person's plan said that they would not want to be admitted to hospital, would like family with them when the time comes and peaceful and relaxing music playing.

We saw that people's information was in the main kept on the electronic system with some paper copies held. We saw this information was kept in office spaces that were kept locked when not in use. We saw that were confidential information was kept on a board in an office that a blind was in place to keep the information private.

Good

Is the service responsive?

Our findings

We observed the morning handover meeting between the oncoming day staff and the nurse from the night shift. We saw that the handover was thorough. The day staff team received an update about all the people who used the service. Any concerns about people were discussed and what action needed to take to support them. We also heard people's personal preferences being discussed, for example respecting the choice of a person not to wear their leg braces during the night and another person not wanting to go to hospital, "[Person] doesn't want to go to hospital. We've documented [persons] wishes and so [person] will stay here." This meant people's decisions about the care and support they received were respected.

A written handover sheet was completed as part of the handover. Senior staff allocated to each floor then completed a daily allocation sheet that showed, who was the nurse in charge, and divided staff into teams to help ensure all tasks were completed. This included supervision of the lounge areas, fluid balance and turn charts were completed, ensure fluid intake from the tea trolley, who was responsible for activities. We saw that seniors had daily checks to complete to ensure medicines administration sheets and cream charts, food, fluid and observations were completed and this was signed off by the seniors.

We saw in the main office that the deputy manager reminded nurses and care staff to ensure that people's glasses, teeth/dentures and bedding were clean and that hearing aids worked.

We saw that were people were nursed in bed who had capacity had access to their buzzer to alert staff if they needed assistance.

At our last comprehensive inspection, the service had just introduced an electronic care planning system and the further development was in progress. At this inspection we found that the electronic system was embedded into the day to day running of the home. There had been some problems with the wifi system but this was being addressed by the home during our visit.

We looked at the printed version of care records for six people who used the service who had different care and support needs. The deputy manager said, "Carers know the residents and relatives really well. We want them to be more involved in the care planning process."

We saw that information included a wide range of care plans, for example, safety and wellbeing plan, illness and medical condition care plan, mobilisation, personal care and physical wellbeing, skin care, sleeping, communication, daily life and social activities, elimination, behaviour, pain, a sexuality care plan, medication and oral health care plan.

We saw references to personal preferences on the care plans, for example,' person likes to wear a suit and shirt and aftershave, they have brought their duvet and blankets from home and likes a warm milky drink before bed and chats to help relax before going to sleep and prefers only females to come into their room.' We also saw two 'What's important to me' one page profiles, which included information such as, 'I like my glasses and buzzer near me, I like to know where staff are, I panic a bit if I cannot find something and my

goal is to just be happy, tell jokes and eat lots of sugar! I love jigsaws and colouring.'

The records we saw had been kept under review. We were told that people and their relatives were involved in developing their care plan. However, this was difficult to evidence due to the computerised system.

When we arrived at the home we found that decorations were up throughout the home in preparation to celebrate Halloween, for example, pumpkins that had been carved the previous day. We noted that people who were nursed in bed had also been involved in Halloween and we saw tombstones and stickers on their beds. One person said, "I like that blackbird and I am going to keep it there." During the afternoon there was a Halloween party and staff had dressed up to help celebrate the event. On the second day of the inspection we saw a quiz taking place in the main lounge downstairs.

Although we saw activities taking place throughout the inspection, some people who used the service and their relatives felt the activities could be improved. People told us, "I'd like a DVD that I haven't seen and to watch it without being disturbed."

The home had recently appointed a carer into the activities coordinator role. We saw that since our last inspection an activities room had been created with resources for people to access and use, or just somewhere quiet to sit. The management team told us they were aware that further improvements were needed to the activities available at the service. They told us they were looking into new activities to improve the choice for people and a second activities co-ordinator so that people with dementia had more input.

Some people who were more independent told us about how they went out by themselves. They told us, "I let [receptionist] know I am going out and when I coming back. I used to enjoy fishing. [Registered manager] has bought me fishing gear. I have been once and look forward to going again. I manage my own money. I have got the best of both world's here."

We reviewed the complaints folder for the home where a number of informal comments had been recorded and treated as complaints. The registered manager explained that they felt it was important to document concerns to help identify any trends, which enabled them to make improvements. We saw a written response to a complaint, which detailed a number of actions that had been taken. The complainant had written back thanking them for the actions taken and saying situation was much better now.

Good

Is the service well-led?

Our findings

At the last inspection undertaken on 25 April 2017, the registered provider had breached Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's quality assurance systems were not always effective. This was because they had not identified the shortfalls we had found during the inspection and because there was no registered manager at the service. The overall rating for this key question was requires improvement.

Following the last inspection we asked the provider to complete an improvement action plan to show what they would do and by when to improve the key questions to at least good.

The service had a manager who had worked at the service since April 2017, initially as an operations manager and registered with us on 17 August 2017. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A deputy manager who was also the clinical lead for the service supported the registered manager. The deputy manager was a Registered General Nurse (RGN) and Registered Mental Health Nurse (RMN) and had more than twenty five years' experience in nursing and teaching in health and social care to students to degree level and in practice. The registered manager and the deputy manager told us though difficult at first, they now thought they had found common ground and complimented each other's strengthens and weakness and were clear about their roles. They met regularly to analyse where they were up to and where they wanted to go and had pulled together.

At the time of our inspection, a quality assurance manager was supporting the managers. This was because the registered manager had had a short period of absence. The deputy manager told us that the quality manager had a good eye for detail and they had been ensuring that paperwork was appropriately completed and consistent standards were being sustained.

Staff said, "We are glad [registered manager] is back. [Registered manager] is a manager and wants us to be organised", "Everyone loves [registered manager] he is very approachable and try's hard to cover shifts. He listens." Others said, "We were worried he would leave. He is strict though, he has high expectations of us, particularly completing paperwork and residents come first" and "[Registered manager] does not want to be beaten. [Registered manager is not putting up with regular staff sickness and has put his foot down." They said the deputy manager kept morale high. Staff said, "She is amazing the way she presents herself. Firm but fair with clear expectations. Top notch." In the main office, the deputy manager had written on the wipe board "changing hearts, changing minds, changing cultures" and thanked staff for all their hard work.

The management team told us that their priority since our last inspection had been to reduce the numbers of agency staff at the home, which had a direct correlation to the errors and mistakes being made and reduce levels of sickness of permanent staff by addressing patterns and trends of absence. They also said

that they wanted to promote good teamwork and had worked hard to improve medicines management.

Relatives we spoke to told us that they felt the management team were approachable and would act on issues they raised. A relative told us, "I'm happy to speak to the manager and [registered manager] is happy for me to raise things. [Registered manager] has made changes for the better." Another relative told us, "The team as a whole have made changes, I can go to anyone and ask them anything. There have been massive changes."

Staff also felt supported. They told us, "The manager will back me up, he's very supportive." "[Registered manager and deputy manager] have proper built this home up. I used to dread coming to work. I would definitely let my relatives live here now." Staff told us they were having more team meetings and more staff were attending them.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. This ensured they provided people with a good service and met appropriate quality standards and legal obligations.

We saw that the manager on duty completed a daily walk round of the home. Later in the morning there was a daily morning meeting at which managers, nurses, senior carer staff, the chef, housekeeping and the administrator attended to discuss any issues and plan the day ahead.

We saw a copy of the SIP which had been updated on 27 October 2017. The SIP showed that the regional manager and a quality assurance manager had kept it under review. We noted that any required actions were not signed off the SIP unless improvements had been sustained. We could see any new areas of identified concerns being added to the SIP for monitoring.

We saw that two managers also carried out an unannounced night visit at 4 am just prior to our inspection. This visit helped to give managers oversight of standards achieved during the night.

In the main entrance to the home, noticeboards displayed feedback from recent resident and relative surveys. The home operated a scheme where care staff are encouraged to become a champion where they take a particular interest in some aspects of people's care, for example, dignity or dementia care. The photographs and names of these staff were also displayed.

There was an employee of the month scheme where anyone can nominate a member of staff. We saw the nominations from the previous month. Approximately half of the nominations were from people who used the service, which demonstrated their involvement in the process.

We saw that the last rating for the home was displayed in the reception area along with a full copy of the report. Before our inspection, we checked the providers website, which also gave the current rating of the home.

Before our inspection we checked the records we held about the service. We found that the registered manager had notified CQC of any accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were kept safe.

We received information from the local authority quality assurance officer. They told us that they had split

the annual monitoring task over more regular visits to ensure that stable and consistent management was being maintained. They had visited the service on 1 September, 15 September and 11 October 2017 to help ensure this was happening.