European Healthcare Operations Limited

Hill Ash House Care Centre

Inspection report

Hill Ash House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 28 and 29 November 2016 and was unannounced.

Hill Ash House Care Centre is a care home for up to 36 people, located in the village of Dymock. At the time of our inspection there were 33 people living at the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Some aspects of the management of people's medicines around storage and transcription checks were unsafe with no significant improvement since our inspection in June 2015.
Systems in place to check the quality of the service provided had falied to address the issues with medicines.

There was an inconsistent approach to assessing people's mental capacity in relation to decisions about their care.

Hill Ash House had a registered manager. 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.

We heard positive comments about the care home such as "Nothing I can find wrong" and "Very, very contented".

People were protected from the risk of being cared for by unsuitable staff because robust recruitment practices were operated.

Sufficient staffing levels were maintained and staff were supported through training and supervision to maintain their skills and knowledge to care for people. Risks to people's safety were identified, assessed and appropriate action taken.

People had positive relationships with the staff team. They were treated with respect and kindness and their privacy and dignity was upheld, they were supported to maintain their independence as much as possible. People took part in a range of activities.

Staff received support to develop knowledge and skills for their role and were positive about their work with people. The registered manager was accessible to people using the service and staff. Surveys had been used to gain the views of people and their relatives.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe.

Medicines were not always stored correctly and checks had not been always been made on the accuracy of hand written directions for giving people their medicine.

Risks to people relating to their care and from the environment were assessed and monitored.

People were protected against the appointment of unsuitable staff because robust recruitment practices were operated.

People were protected from the risk of abuse because staff understood how to protect them.

Is the service effective?

Requires Improvement

The service was not fully effective.

There was an inconsistent approach to assessing people's capacity to consent to decisions about their care.

People were cared for by staff who received appropriate training and support to carry out their role

People were supported to eat a varied diet.

People were supported to maintain their health needs.

Is the service caring?

Good

The service was caring.

People benefitted from positive relationships with the staff.

People were treated with respect and kindness.

People's privacy, dignity and independence was understood, promoted and respected by staff.

Is the service responsive?

Good

The service was responsive.

People received individualised care and support.

People were enabled to engage in activities and social events.

There were arrangements to respond to any concerns and complaints by
people using the service or their representatives.

Is the service well-led?

Requires Improvement

The service was not as well-led as it should be.

Checks were in place to monitor the quality of the service provided however these checks had failed to identify issues with medicine storage and recording.

A registered manager had been in post since September 2016.

The registered manager was accessible and open to communication with people using the service, their representatives and staff.

Hill Ash House Care Centre

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 28 and 29 November 2016 and was unannounced. Our inspection was carried out by one inspector 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. Their area of expertise was the care of older people.

We spoke with four people who used the service and two visiting relatives. We also spoke with the registered manager, the group care manager, the head of care and four members of care staff. We saw how staff interacted with people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We carried out a tour of the premises, and reviewed records for four people using the service. We also looked at seven staff recruitment files. We checked the medicine administration records (MAR) and medicine storage arrangements for people using the service. We also checked records relating to the management of the service.

Before the inspection we looked at notifications the service sent to us. Services tell us about important events relating to the service they provide using a notification.

Requires Improvement

Is the service safe?

Our findings

At our inspection of June 2015 we found medicines were not always stored correctly and people's medicine records were not always managed safely. Medicines had not always been kept at the correct temperature. Handwritten directions for giving people their medicines had not been signed by the staff who entered the directions on the administration chart or checked for correctness by a second member of staff.

The provider wrote to us about the improvements they were making to medicines storage and recording. They told us the improvements would be completed by the end of August 2015 and included the installation of air conditioning in the medicine storage room.

At this inspection we found medicines had not always been stored at the correct temperature. When we entered the medicine storage room on the first day of the inspection the recorded temperature was higher than that indicated for the storage of people's medicines. The air conditioning unit was not operating. The maintenance worker was summoned to switch the air-conditioning on. Records for the month of November 2016 showed that temperatures in the medicine storage trolleys had exceeded 25 degrees centigrade on sixteen days. If medicines are not stored properly they may not work in the way they were intended and so pose a potential risk to the health and wellbeing of the person receiving the medicine.

We also found some hand written directions for giving people's medicine had been written on the current medicines administration record (MAR) by staff. These included antibiotics, an ointment and medicine for iron deficiency. However there was no signature for the staff who entered the directions on the administration chart and a second member of staff had not signed these directions to indicate they were checked and correct on nineteen handwritten directions for eight people using the service.

We found that the registered person had not protected people against the unsafe use and management of medicines. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff responsible for administering medicines had received training and had passed competency assessments. Information was recorded and included with people's MAR about how people preferred to take their medicines. Individual protocols were in place for medicines prescribed to be given as necessary. There were records of medicines being received into the home and being disposed of when required. An error had been made in giving a person their medicine by a member of agency staff. We discussed this with the registered manager and the group care manager who had taken appropriate action.

People were protected from the risk of abuse because staff had the knowledge and understanding to safeguard people. Staff were able to describe the arrangements for reporting any allegations of abuse relating to people using the service and contact details for reporting a safeguarding concern were available. Staff were confident any safeguarding concerns reported to the registered manager would be dealt with correctly. People using the service and their relatives told us Hill Ash House Care Centre was a safe place to be. People were protected from financial abuse because there were appropriate systems in place to support

people to manage their money safely.

People were protected against identified risks. For example there were risk assessments for falls, pressure area care and nutritional risks. These identified the potential risks to each person and described the measures in place to manage and minimise these risks. Risk assessments had been reviewed on a regular basis. People were protected from risks associated with fire, legionella, scalding and electrical systems and equipment through regular checks and management of identified risks. The operation of a clinical risk register highlighted any clinical issues people may have, such as weight loss or an infection, for action. This included referral to health care professionals.

People were supported by sufficient staffing levels. Although staff described how busy they were, one staff member told us "We don't work short" and described the use of agency staff to cover absences. We observed staff attending promptly to people's needs when required and staff were present at all times in communal areas while others provided care and support to people in their individual rooms. The group care manager described how a new 'twilight' shift was being introduced to support the late shift and the night shift. This was also considered to be suitable for the needs of people living with dementia who may experience distress during the evening. One member of staff thought this would make a positive difference and another said "we could do with an extra one".

People were protected against the employment of unsuitable staff because robust recruitment procedures were followed. Checks had been made on relevant previous employment as well as identity and health checks. Disclosure and barring service (DBS) checks had also been carried out. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Liquid hand gel was available at points in the home such as the reception area and the staff entrance door. An infection control audit had been completed in March 2016. An inspection of food hygiene by the local authority in November 2016 had resulted in the four out of a possible total of five stars being awarded.

Requires Improvement

Is the service effective?

Our findings

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care plan files contained documents to assess people's capacity to consent to decisions about their care. However examples we read had not been completed correctly. The section for recording the specific decision to be assessed had been completed with information about whether a person had mental health issues, a sensory impairment or was living with dementia. Therefore this did not provide an accurate assessment of a person's capacity to consent to receiving care. The registered manager and group care manager were aware of this and described a plan for a review of the assessment forms. Applications for authorisation to deprive people of their liberty had been made including assessments of their mental capacity. No applications had been authorised for people using the service at the time of our inspection visit. Staff had received training in the MCA and demonstrated their knowledge of the subject.

People using the service were supported by staff who had received training for their role. Staff told us they had received training such as moving and handling, diversity and health and safety. Records of staff training confirmed this. Training specific to the needs of people using the service had also been completed such as dementia and diabetes. One member of staff commented, "The training is really helpful". The registered manager had identified a need for more training for the staff team and had organised this through the local care home support team. Subjects for training included accountability and documentation and person-centred care. Staff new to the role of caring for people had completed the care certificate qualification and their induction included shadowing an existing member of staff for two weeks. Staff had regular individual meetings called supervision sessions with the manager or a senior member of staff. The registered manager described a plan to introduce observations of staff practice in place of supervision meetings. People described staff as "excellent" and "attentive".

We saw people served breakfast and lunch on the first day of our inspection visit. At breakfast some people were eating a cooked breakfast, we also saw people offered a choice of drinks. Each person that arrived for breakfast was greeted by name and given the food and beverage they liked. We were told breakfast could be served in people's rooms – "if they like it more personal and quiet". One person commented positively about the breakfast telling us they "always enjoyed it, the coffee is always nice". The dining area was clean, tables laid and people were provided with protective clothing if required. Food was described as "excellent", "very nice", "plentiful" and choices offered. Snacks were available outside of normal meal times and on people's request. We saw hot drinks given to people during the late morning. Staff knew people's preferences for hot

drinks such as tea or coffee. A selection of prepared fresh fruit was available and we observed this was eaten by most of the residents.

People's healthcare needs were met through regular healthcare appointments. One person told us "if I felt unwell they would ring the doctor". Care records indicated that other health professionals are involved in the provision of care such as occupational therapists, physiotherapists and visits to local dentists. A district nurse was visiting and treating people at the time of the visit.

Good

Is the service caring?

Our findings

We observed staff talking with people in a warm and friendly manner. People described staff as "excellent", "very nice people to look after you" and "attentive and very nice." We also saw good rapport and laughter when staff interacted with people. We also observed interactions delivered in a manner which was kind, compassionate, sensitive and respectful. Staff regularly checked on people's well-being and were observant to people's needs such as closing a curtain when the sun was shining directly into one person's eyes. Copies of the mission statement, philosophy of care, and personalised care were on display. A relative of a person using the service commented positively about the patience of the staff and told us "her care has been superb", they added "nothing is too much trouble". Positive written compliments had been received from people using the service and their relatives relating to the caring approach of staff. An audit tool for dignity and respect had been prepared for future use.

People had the opportunity to attend resident's meetings to give their views on the service provided. Meetings were held on a monthly basis. People were consulted about their views on personal care, food and drink, activities and how their laundry was managed. Information about local advocacy services was available at the home. The registered manager had knowledge of where the use of such services may be appropriate. Three people had used the services of a lay advocate. Advocates are people who provide a service to support people to get their views and wishes heard.

We saw how doors were closed when staff entered a person's room to provide care. One person using the service told us "They always knock on the door". Another person told us staff were "Very good at knocking doors". Another person confirmed they were able to "keep their dignity and able to make choices". Another told us their "Dignity was respected all the time". We observed how staff quickly dealt with one person's care needs without negatively impacting on their privacy and dignity. Any preferences for the gender of staff providing personal care was recorded.

People were supported to maintain their independence. Care records contained information and advice tailored to support people who wished to maintain independence but were unable to recognise the potential risks to themselves in doing so. Staff gave examples of how they would promote people's independence such as offering people a choice of clothes to wear on a daily basis and offering choices at meal times.

People were supported to maintain contact with family and friends. People told us they went out for meals with relatives and of relatives visiting. One person told us about their relative's involvement in assisting with their care needs and the positive impact it had on their ability to enjoy her meals. During our inspection we spoke with people's relatives who told us how they were welcomed when visiting the care home. Relatives were kept up to date with developments at Hill Ash House Care Centre through regular meetings.

The registered manager described a good relationship with district nurses and how this enabled staff to care for people at the end of their life. We saw and heard compliments from relatives about the care provided to people in their final days and the support given to people's relatives. This included arrangements for one

person's relative to stay in the person's individual room.

Good

Is the service responsive?

Our findings

People received personalised care and support. We saw how the service had responded to meet the individual needs of people and listened to their views and wishes. Interactions between staff and people demonstrated that staff took account of and responded to individual needs. Examples we observed included speaking loudly and clearly to those with hearing impairment and a calm unhurried approach to those with mobility problems. Some people living with dementia received comfort from dolls which they held; this was known as 'doll therapy'. Suitable adaptations had been provided in the bedrooms of people with sensory impairment such as flashing light door 'bells' and vibrating devices to alert them in the event of fire. Staff knew the people they cared for and their individual needs, for example providing individual breakfasts and support for a married couple. Care plans were personalised with specific and individualised information about people's care needs and the actions for staff to take to meet them. For example recording people's preferred times of going to bed and getting up. A member of staff told us the approach to providing personalised care was "Not, one size fits all".

People took part in a range of appropriate activities. People had recently been involved in making Christmas puddings and photographs of this activity were on display. A timetable of events was on display on a notice board. Support for maintaining hobbies and interests was evident such as cooking, pottery, cake making, and magazine reading. On the afternoon of the second day of our inspection visit, people were enjoying a bingo session. We saw how the activities coordinator worked closely with people, engaging them in activities. One activity we observed involved people tasting food items with their eyes closed on an individual basis. This was clearly enjoyed by people taking part and a positive change in their mood was evident.

People were positive about the range of activities including any trips out provided saying they "enjoyed getting away from the usual routine". The home's minibus had been out of use but a local minibus service had been used so that people could continue to take part in activities outside of the care home such as visiting a local Victorian tea room. Weekly holy communion was available to people in the care home. Links have also been made with a local church and people could attend church lunches.

There were arrangements to listen to and respond to any concerns or complaints. Records showed, complaints were recorded, investigated and responses provided to complainants. Where relevant, remedial action was taken as a result of a complaint or concern. For example a new carpet was planned for one of the communal rooms. Another complaint investigation had led to an improved awareness for staff of issues around people's dignity and respect. This had been addressed through improved supervision for staff and dignity and respect discussed at staff meetings. During our inspection visit the group care manager was at the care home investigating a recent complaint. Information on the complaints process was also on display, alongside other notices. Residents and relatives' meetings enabled people and their representatives to raise any issues about the service.

Requires Improvement

Is the service well-led?

Our findings

Despite a number of audits completed for various aspects of the service provided the registered provider had failed to ensure a previous breach of regulation had been met in relation to the storage and recording of people's medicines. An action plan produced by the service to address the issues relating to medicines found at our inspection in June 2015 had not been fully implemented.
Audits resulted in action plans where areas had been identified for improvement. A range of audits were carried out such as a facilities audit (checks on equipment and the care home environment), a monthly nutrition and hydration audit, an accident audit and hand hygiene audit. A quarterly quality assurance audit was also in place covering a range of areas such as care plans files management processes and health and safety. Quality was also checked through regular visits to the care home by representatives of the registered provider. However the quality assurance processes in place had failed to address the issues with the storage and recording of directions for people's medicines identified at the previous inspection.
This was in breach or regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager who had been registered as manager of Hill Ash House Care Centre since September 2016. A registered manager is a person who has registered with 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 and associated regulations about how the service is run. The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred. However we discussed with the registered manager the need to submit notifications when the outcome of a DoLS application was known whatever the cause.

The registered manager described the approach of the service was to treat the care home as the residents home stating "this is their home until they leave us". They also described a vision to further develop the service for the needs of people living with dementia and support their relatives. This also included consideration of any changes to the environment of the care home such as more personalisation of people's individual rooms. A recent training session about dementia had included an invitation to people's relatives to attend. The registered manager described the challenges of managing the environment of the care home and the need to ensure thorough assessments were made of people's needs to ensure these could be met before they moved into the care home. They described a good level of support from the registered provider. Copies of the mission statement, philosophy of care, and personalised care were on display. Staff were kept informed about any issues or developments with the service provided through regular meetings. People using the service, their representatives and staff all told us how the registered manager was approachable and accessible. One staff member told us "the manager's door is always open".

Staff demonstrated a clear awareness and understanding of whistleblowing procedures within the provider's organisation and in certain situations where outside agencies should be contacted with concerns. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

The views of people using the service and their representatives had been sought through annual questionnaires. Views were sought on aspects of the service provided. Any areas for action were documented and allocated to individual or groups of staff with timescales for completion. Examples of where action was being taken based on comments included playing music in communal areas, refurbishing of communal rooms and one person who did not wish to be woken in the morning so early.

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 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate arrangements were not in place to protect people against the unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not operated effective systems to ensure the monitoring and improvement of services.