Leonard Cheshire Disability

Hill House - Care Home with Nursing Physical Disabilities

Inspection report

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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

This inspection took place on 27 and 28 September 2017 and was unannounced.

The service was previously inspected in May 2015. The registered provider was complying with all regulations at that time..

Hill House is a care home providing both accommodation and nursing and personal care for up to 23 adults who have a physical disability. The service is provided by Leonard Cheshire Disability. The home is a modern purpose built facility and includes a bungalow separate to the main building. All bedrooms are single and have en-suite bathrooms fitted with overhead hoists. A passenger lift is installed to access the two floors. On the day of our inspection the service was providing accommodation and nursing care to 20 people.

There was a registered manager in post although they were not 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 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 identified four breaches of relevant legislation in respect of safeguarding service users from abuse, safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of this report.

Overall the people and relatives we spoke with were positive about the care and support received at Hill House.

People told us that they felt safe from abuse and harassment and trusted the staff. However, we found that not all staff could demonstrate a clear understanding of the procedures they should follow if they witnessed or suspected that abuse had taken place. We were told about concerns by a member of staff and that they had not passed them on. As a result they had not been investigated or reported to the local authority and the Care Quality Commission (CQC) as required. This meant that people were not fully protected. We brought this to the attention of the deputy manager at the time of the inspection and it was then dealt with appropriately.

We saw that risk assessments had been recorded in people's care records and that weight loss and pressure ulcer risks were regularly monitored. Accidents/incidents were not always recorded and we found that recording was not sufficiently robust.

Medicines were administered safely although we found that in some areas management systems needed to be improved. We saw that regular audits were taking place. There were two recent instances of missing

medicines and we found that the process used for checking stocks needed to be reviewed.

At the time of the inspection we found that there were sufficient staff. Some people and staff told us that there were sufficient staff to meet their needs whilst others felt that this was not the case at night and weekend. We saw that staff received an induction and training was provided. Staff told us that they received the training and support they needed to carry out their roles effectively. Staff were also supported through supervisions although we saw that some were behind schedule. We found that safe recruitment systems were in place.

The environment was clean, spacious, fit for purpose and well decorated. Recent improvements had been made with the construction of an orangery extension and a sensory garden. Further works were planned to create an activity and physiotherapy centre within the grounds.

We were provided with two different versions of an emergency plan. We found that these lacked sufficient detail and guidance for staff in the event of a full evacuation. Following the inspection we received additional details which provided this information. A personal evacuation plan detailing each person's individual needs was also in place.

We checked whether the service was working within the principles of the MCA, and whether any conditions to deprive a person of their liberty were being met. It was evident that the deputy manager had a clear understanding of the MCA and its application.

We saw that people's nutritional needs were being met. People had choice and the food was of a high quality. People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were knowledgeable about people's nutritional needs.

People received care that was personalised, effective and responsive to their needs. Care plans were detailed and contained sufficient information to enable staff to meet people's needs. People spoken with told us that they were given choices about the way in which their care was delivered.

People looked happy, well cared for and were supported to maintain their independence. Staff were observed interacting in a kind, caring and attentive manner. An advocacy service provided by Leonard Cheshire Disability was available.

The home had two activities co-ordinators and there was a varied programme of activities taking place. Fully adapted transportation was available for outings. The service was supported by a well organised volunteer programme.

There was a complaints procedure available and people told us they knew how to complain should they need to. Regular meetings were held with the people living at Hill House and they were involved in decisions about their home.

We found that the home had systems in place to assess and monitor the quality of service, however actions identified were not always followed up and the systems had not been sufficiently robust to identify some of the issues raised during this inspection.

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 consistently safe.

People told us that they felt safe and trusted the staff.

Some staff were unable to give an explanation about safeguarding, actions to take and how to escalate concerns. We were told about a concern which had not been reported.

Accidents/incidents were not always recorded and records were not sufficiently robust.

Checks were in place to ensure the suitability of the staff employed at Hill House.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People felt their care and support was effective and met their needs.

Staff had an awareness of the need for consent and an understanding of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards were being applied appropriately to people within the home.

Staff had not always had appropriate training, supervision and appraisal to enable them to carry out the duties they were employed to perform.

There had been recent improvements to the indoor and outdoor environment.

Is the service caring?

Good

The service was caring.

People told us that they were treated in a kind and caring manner and we saw that good relationships had been developed.

People were supported to express their views and were involved with decisions about their care.

We observed that people's privacy, confidentiality and dignity were maintained.

Is the service responsive?

Good

The service was responsive.

People had care plans which were personalised, detailed and reflected people's individual needs.

People were supported to take part in a wide range of activities to meet their individual needs.

We found that staff were motivated and positive about their roles and the care they delivered.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff told us that they felt well supported and that management were approachable and fair.

Management operated an open door policy.

There were some systems in place to monitor the quality of the service but these were not always sufficiently robust and actions identified during audits were not always addressed.

Hill House - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 September 2017 and was unannounced. The inspection was carried out by one adult social care inspector, one adult social care inspection manager and an expert by experience on the first day and one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was aware of our visit to conclude the inspection on the second day.

The registered manager had completed a Provider Information Return (PIR) before this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events which the provider is required to tell us about by law.

We contacted the local authority before the inspection and they shared their current knowledge about the home. We checked to see whether a Health Watch visit had taken place. Health watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. A recent visit had not taken place.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with six people who lived at the home and three visitors to seek their views. We spoke with nine members of staff including one nurse and the deputy manager. Following the inspection we contacted health services who visit the home.

We also spent time reviewing specific records and documents related to the day to day management of the service. These records included care records for three people who used the service, staff rotas, quality audits, training, supervision and induction records and maintenance records. We toured the building and sensory garden and with permission spoke with some people in their bedrooms. We observed the lunchtime meal on the first day and throughout the inspection we made observations of the care and support provided to people.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe and well cared for. All told us that they did feel safe from any sort of harm or harassment. People told us that they would speak to the person in charge if they didn't feel safe. Comments included "Our key workers are excellent", "Can't fault it, 100%" and "Staff are excellent, I trust the staff".

We saw that there was a process to record accidents and incidents although we found this was not sufficiently robust. Staff were able to explain the process they should follow. However, the file provided did not contain records for all accidents/incidents that had taken place. For example we had been made aware of an incident prior to this inspection but there were no details of this incident in the file. Records also lacked information about the investigation carried out. For example, one record noted that a person had suffered a fracture but there was no information as to how this accident had been investigated to identify the cause and any actions that may need to be taken to prevent recurrence.

We were informed that details from the accident forms were transferred to a computer system but there was no corresponding accident/incident form on file in relation to the computerised record provided. A summary sheet reviewed of accident/incidents which had occurred did not match with the ones on file or with the computer record provided. We noted that accident/incident forms were retained in other places such as with safeguarding and complaint records. This, along with the discrepancies in recording noted above, meant that there was no overall record of all accidents/incidents which had taken place to enable managerial oversight and to identify themes and trends. The systems to monitor and assess the quality of the service and to monitor, assess and mitigate risk are discussed more fully in the well led section of this report.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems or processes had not been established or operated effectively to ensure compliance with the regulation.

The provider had policies in place for safeguarding adults at risk of harm from abuse or neglect and for whistleblowing. The policies contained guidance about the action that should be taken in response to any concerns and to encourage people to come forward. We reviewed the safeguarding file and saw that it contained records relating to incidents that had occurred. There was evidence that these incidents had been reported to the local authority and to the CQC. Training about safeguarding was provided as part of the induction programme and the annual refresher programme.

Some staff told us that they felt able to raise concerns and that they would be listened to. However, others spoken with were unable to give a clear explanation about safeguarding, actions to take and lines of escalation. One staff member gave details of concern they had been made aware of which they should have reported but had not done so. This meant that the concerns had not been reported to the local authority or the CQC and had not been investigated. Details were passed to the deputy manager at the time of the inspection and were followed up appropriately.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to establish and operate effectively a system and process to prevent abuse of service users.

We reviewed the management of people's medicines. Medicines were stored in a lockable cabinet in each person's room. There was a treatment room with appropriate equipment for managing medicines. Additional supplies were kept in a locked cupboard and stock levels were managed effectively. We saw that the provider had a policy in place for the management of medicines which was stored in the main office. We recommended that this should be stored in a place accessible to staff at all times, such as the treatment room.

We were told that staff responsible for medicines had completed training and assessments were carried out to ensure their competency. We spoke with the nurse who demonstrated a good understanding of people's needs around medicines and also about safe practice. Some people had medicines which were to be taken pro re nata (PRN), which means when necessary, for example pain killers. Although the service did not use a formal rating to assess pain, staff advised they knew how people indicated non verbally that they were in pain.

We saw that a record of administration was completed on the medicines administration record (MAR) in each instance following the administration of medicines. Each MAR included a photograph of the individual to ensure that medicines were administered to the correct person. There was a process in place for the safe management of the use of oxygen.

Prior to the inspection we had been made aware that some medicines were missing. We were informed that an initial investigation identified that staff had not followed the correct process when the medicines were delivered. During the inspection we were informed that another medicine was missing. This was to be investigated and we requested that the deputy manager carried out a full medicine count to ensure that there were no other concerns. Following the inspection we were informed that all other medicines were present and correct.

There was a process in place for weekly medicine audits to be completed which were usually carried out on time. A full medicines audit was carried out in August 2017. A monthly stock take was also carried out by each named nurse. This ensured that there were sufficient stocks available however it was not clear whether the stock count had been compared with the MAR to ensure that medicines in stock tallied with that record. We discussed this with the deputy manager who was not able to confirm whether this had occurred. Therefore, we could not be sure that the audit was sufficiently robust.

Systems were in place for fridge temperature checks and medicine disposal. If medicines were not stored properly they may not work in the way they were intended, and so would pose a potential risk to the health and wellbeing of the person receiving the medicine. We found that the treatment room was very hot. We saw that this issue had been identified in an audit carried out by the provider in April 2017 and an action had been noted to purchase an air conditioning unit. We were informed that quotations had been obtained but that the unit chosen was no longer available. We requested that this is resolved as quickly as possible to ensure that the quality of medicines is maintained correctly.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure the proper and safe management of medicine.

We reviewed how risks to individuals were managed. Risk assessors were employed to manage risks

associated with individual's care including moving and handling techniques. We saw that detailed moving and handling assessments were carried out which had tick boxes to confirm when the manoeuvre was seen to be effective. However, we noted that this element of the assessment had not always been completed; therefore it was not clear whether the risk assessment was meeting the person's needs.

Records showed that other risks to people had been assessed and were linked to care plans, this identified the risk and the support that was required to minimise that risk. Risks that had been assessed included skin integrity, bathing and showering, health conditions, malnutrition and nutritional support.

At the time of the inspection building work was on going with regard to the creation of new bedroom facilities. This work was managed effectively to create the least disruption and corridors were kept free from obstacles.

Sluice facilities were available on both floors however it was noted that not all facilities were locked, this was brought to the attention of the deputy manager who confirmed during the inspection that she had made enquiries and that locks were to be fitted.

The environment was kept clean, well decorated, maintained to a high standard and was free from odours. There was a link nurse for Infection Prevention and Control and regular audits were carried out. Measures were in place to prevent the spread of infections including staff wearing appropriate personal protective equipment, gloves and aprons were readily available and each person had their own sling for use with hoists.

At the time of the inspection there was one nurse and eight health care assistants on early shift, reducing to one and four in an afternoon and one and two for night shift. During the inspection we found that there was sufficient staff to meet people's needs and provide personalised care and support. We saw that call bells were answered quickly and that staff had time to chat with people.

We looked at rotas, audits relating to call bell times and spoke with people using services and staff about staffing levels within the home. Staff told us they felt there were sufficient staff at the moment "because we are not at full capacity" and said "We are never at an unsafe staffing level." However, some people told us that they had to wait longer when staff didn't turn in and that there was "Not always enough time to talk to people".

The deputy manager told us that staffing levels were increased when needs changed for example they had been increased by one health care assistant to support the admission of a person. We saw that when required staffing was provided on a one to one basis. A dependency tool was completed for each person and reviewed each month, however we were told there was no clear link to how staffing levels were determined and staff told us that staffing levels were "not always" increased in line with dependency. We would recommend that the provider uses a tool which would clearly link dependency to staffing needs.

We were told that there was one vacancy for a full time health care assistant and that staff retention was good. Permanent staff usually covered sickness and leave absence by picking up additional shifts and agency staff were used when necessary. One agency was used to provide consistency of care and a profile was obtained from the agency which demonstrated that the staff member has received appropriate training and checks had been made with the Disclosure and Barring Service (DBS) to confirm their suitability to work with adults at risk of harm.

Recruitment practices were checked to ensure that they were safe. There was a record of comments made

during interview but these were not always signed or dated by the persons carrying out the interview. We found that in the past clearance had not always been received from the Disclosure and Barring Service prior to the person commencing their employment. These checks aimed to help make safe recruitment decisions to prevent unsuitable people from working with vulnerable groups. For example, we found that a person had commenced employment prior to receipt of the DBS check and satisfactory references. Although we were informed that the person had not worked alone until that information had been received we saw no evidence to support this comment. However, we saw that more recently recruitment practices were safe.

We were provided with a copy of an emergency plan. This was incomplete. Pages were missing and it did not contain information about how to evacuate people safely if needed. We discussed this with staff who stated that the police and local authority would find a place of safety in such circumstances. The provider should have a detailed plan in place with guidance for staff and we asked for this to be provided.

Following the inspection we were provided with another document dated September 2017. This document contained contact details for the local authority Emergency Planning Unit and a flow chart dated January 2007. We contacted the local authority using the number provided in the document and were informed that they were unaware of such a plan for individual care homes. We contacted the local authority contracts team and safeguarding lead as we had still not been provided with an appropriate plan for full scale evacuation. We have since been provided with a copy of the procedure staff would follow in the event of a full evacuation of the premises.

We saw that a personal evacuation plan was in place for each person. This details the support and equipment each person would require in the event of an evacuation. A fire risk assessment was on file dated 11/10/16. An action plan was included however there was no evidence to confirm that these actions had been carried out.

We saw from records that the provider had arrangements in place for on-going maintenance of the building. Certificates were provided to show that appropriate safety checks had taken place, for example electrical installation, gas supply, portable electrical appliances etc. We also saw that audits and checks were carried out however these were not always up to date for example, weekly maintenance check, hoist check list and room check list last date 13/09/2017. Monthly maintenance check list which included emergency lighting and monthly water temperature checks had not been completed in August.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives whether they found the care and support they received to be effective. People told us that they felt their needs were met within the home and that they had responsive and effective visits from a local doctor who also visited twice a week. They said "Staff look for pressure areas and offer effective support" and "GP is best I've come across". Staff told us that they felt confident and aware of signs and symptoms they needed to be observant for regarding people's specific health conditions, for example diabetes.

We were informed that staff attended an annual training refresher day that covered the areas completed during induction. We were provided with a list of subjects covered as the matrix provided did not include this information. We could see from the matrix that not training was up to date, for example five staff were overdue for the annual refresher day, twelve staff were overdue for a moving and handling session, and six of the ten staff listed as needing to attend annual training for safe administration of medicines were also overdue. Staff told us "You do so much in refresher day so sometimes you don't take it all in" however when we asked if they felt they had received training that enabled them to do their job effectively and were told "Yes, definitely."

From records provided we saw that of the thirty six staff listed, nine had no recorded date for fire training. Records of fire drills were provided however some staff had not attended a drill whilst others had attended several. The records did not state the date and time of the drill nor whether the correct actions had been carried out.

Staff told us that they had had supervisions sessions to discuss their performance and development but that they did not receive a copy of the supervision record. There was also a process for an annual appraisal of performance. We saw from records that there were delegated lines of responsibility with regard to supervision and appraisal management. However we saw that sessions had not always been carried out as scheduled as many had been missed or were overdue. Of the twenty sessions due in August only four were marked as completed and for September of the nineteen marked as due only seven had been completed. We saw that an action noted on the audit carried out by the provider on 10th April 2017 stated "to ensure supervision frequency is followed as per policy" and a quality audit carried out by the local authority quality monitoring team in November 2016 had also identified similar concerns around completion of supervision.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Persons employed by the service provider in the provision of regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. .

In addition to visits from the doctor, people had access to services which supported their health needs such as the dentist, optician, speech and language therapist, dietician and physiotherapist. We saw from records that the provider engaged with these services as and when needed.

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 supported 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.

We found there was a mental capacity framework within the care plans which staff were completing. We saw that applications had been submitted under DoLS as required and had been authorised accordingly, details of the date these would need to be renewed was clearly recorded.

We observed staff seeking consent before carrying out activities and they were able to demonstrate a good understanding of when and how to do so including explaining what they would do if consent was not given.

There had been several improvements to the premises and grounds over the last few months with the construction of an orangery extension and a sensory garden. The orangery was large, light and open providing a spacious area for communal use. During the inspection we saw people enjoying the lounge area, activities and meetings taking place in another section. The sensory garden provided an exceptional tranquil space. A winding path ran through different areas which included interactive music, instruments, animals and sounds, seating and a stream. The area had mood lighting and could be used day and night. We were told that people were already making use of the new garden for example one person sat with their key worker in an evening listening to their music and greatly enjoyed the experience. A grand opening ceremony was planned for later in the year.

There were further plans to convert a bungalow at the end of the garden into an activity and physiotherapy unit. The people living in the bungalow were moving to new bedroom facilities in the main building. We saw that they were excited by the changes and that staff explained throughout what was happening and when their rooms would be ready. Staff worked hard to ensure that the rooms were made available as soon as possible and were seen showing genuine interest when they were being shown around by the new occupants, commenting "It's absolutely lovely".

Premises had been appropriately adapted to meet individual needs. This included tracking for hoists, en-suite wet room facilities and wide, remote control doors.

We saw that meetings took place in order to communicate with people using services and staff. Staff told us that their meetings were not held on a specific schedule but that they found them worthwhile although would like them more frequently.

Minutes from meetings involving people using services evidenced that they were consulted about changes and that individual's choices were considered. For example, people were involved with decisions about the environment and were kept informed of progress in relation to the recent changes. Soft furnishings, furniture and colour schemes were discussed and chosen by people who used the service.

Nutritional needs were clearly identified within the care plans reviewed. Care plans included details of personal choices, likes and dislikes for example "I do not like my plate to be too full as it over faces me". A full time chef was employed and a kitchen assistant for the evening meal. People's nutritional needs were

overseen by a lead nurse. Menus were displayed on the dining tables and a choice of meal was offered each day. Once a week the menu choice was noted as "Perfect Day" and people using services chose what was their "perfect" dish which was then one of the choices available. People were able to choose where they preferred to eat their meals and told us that they had no complaints and that they had a sufficient amount. A vegetarian option was also provided on request. On the first day of the inspection the expert by experience sampled the lunchtime meal and found it to be very tasty.

The food served for the lunchtime meal was observed to be nutritious, of a high standard and was enjoyed by those seated in the dining room. Staff were seen interacting well throughout the lunch time service with one to one support offered discreetly where needed, for example, offering encouragement "You are doing really well, you have come such a long way". Additional food and drinks were offered throughout.

Details of individual's dietary needs were recorded in care plans and held in the kitchen. Staff were knowledgeable about individual's likes, dislikes and dietary needs. There was a sub-kitchen facility in the dining room where staff could make drinks and snacks during the day and when the main kitchen was not staffed. At the time of the inspection the fridge was stocked with items including milk, juice, yoghurt and cake.

Staff received an induction although there was no overall documentation covering the whole induction programme. For example we were informed that part of the induction involved orientation of the building however there was no record made in this regard. We were provided with a list of training covered and told that part of the induction programme involved completion of the Care Certificate and this covered assessment of their competency to carry out their role. The Care Certificate is a set of standards that social care and health workers follow in their daily working life. Staff spoken with told us that they had received an appropriate induction which enabled them to carry out their role effectively.

Good

Is the service caring?

Our findings

Staff were seen interacting with people in a kind, caring and attentive manner, were knowledgeable about people and their needs and we saw that positive and caring relationships had developed. Staff were interested in conversation and were seen to take time to listen and not rush the person they were chatting with. Staff told us they felt people were well cared for because "We care about them and make sure they are well looked after" and "We always pride ourselves on delivering a high standard of care".

People told us that they felt staff were kind, caring and "Very much a good team. We can have a laugh". When asked what staff did well, we were told "Everything, 100%". However one person told us that (Name) had been waiting several weeks for a new wheelchair cushion and that they were concerned that this was causing them discomfort.

We saw that compliments had been received from relatives and friends for example "Appreciated the care and friendship you gave to (Name), what a blessing (Name) is so happy in LC (Leonard Cheshire), I am so pleased and grateful" and "Nurses and carers really do care and go beyond what is expected of them".

When speaking with staff and through observations it was clear that they were proud of the work that they did and for treating each person with respect. We were told that staff chose to come back in their own time to support individuals with activities and outings. Staff told us that "it is a happy place to be, I enjoy coming" and "When I think I've achieved this, it's quite rewarding and a bit overwhelming". Staff said that they felt supported in their role and that they "all help each other". Staff said they would be happy for one of their family to be cared for at Hill House because of the "Attitude of staff and the respect that people get from staff" and we "Work together, smiling and offer choice".

An advocate visited the service to seek views from and support people using services. The person was employed by Leonard Cheshire Disability but independent of Hill House. Posters were displayed around the building with details of the sort of thing the person could help with along with their contact details. We were told that external advocacy services were not used at the present time however would be made available if needed.

People were supported to maintain relationships. Transport that was adapted to meet people's needs, for example wheelchair access, was available and the volunteer programme provided additional transportation for visiting relatives etc. People were able to have visits from family and friends and told us that they had privacy during those visits. Arrangements were made for visitors to stay over when required, for example for early medical appointments.

Confidential records such as care folders were kept securely. Staff were mindful of the need to maintain confidentiality and could explain the steps they would take in this regard. Comments included that they would speak with people privately, not ask questions in front of people and would not shout to each other in the corridors.

We found that people were supported and involved in planning and making decisions about their care. People had been involved in the development of their care plans and told us that they had been consulted with. People told us that they had reviews to ensure that they remained happy with the care they received, comments included "I know what's in, I have a very good key worker".

People were supported to live as independently as possible. Assistive technology was used to promote independence including pendants to maintain safety when mobilising around the premises and gardens. Remote controlled curtains or blinds were fitted in bedrooms and new tables had been purchased which were adjustable in height. We saw that staff gave people time to do things on their own, offering help discreetly and when needed. People told us that staff helped them to be independent saying "Particularly with mobility", "Did a parachute jump" and "by knowing my strengths and abilities".

Information and advice was available in the entrance area and on notice boards. This included information about activities, fire marshals and nursing staff on shift. Staff kept people informed throughout the inspection about what was happening each day.

We found that people's privacy and dignity were respected and promoted. Staff explained how they would provide care that promotes privacy and dignity. People told us that staff spoke about their needs privately and that they were "very much" treated with dignity and respect.

Good

Is the service responsive?

Our findings

People told us staff were "Always there if you need them". We reviewed people's care records and found them to demonstrate a person-centred approach. We saw that each person had folders for health needs, personal needs and a daily narrative which was completed by care staff. Each file contained a document called "All about me" which included a detailed chronology of events that had impacted on life, wellbeing, friendships and relationships. People told us that they felt fully supported and that staff knew their likes and dislikes. Staff told us that they asked people how they wanted their care to be delivered as "A big part of care is communicating." Staff also said "We get to know each resident as a person, we have different conversations". People told us that they felt fully supported and that staff knew their likes and dislikes.

All people spoken with told us that they knew how to make a complaint and felt able to do so. The provider had a complaints procedure in place. However one person told us that "we are in trouble if we complain". We reviewed the complaint file provided and saw that it contained details of complaints and compliments made. We saw that one complaint included reference to poor quality food however the response on file did not include details of how this element had been addressed. Information was not always clearly recorded about how complaints had been investigated and the outcome. There was also no summary sheet to identify any themes, trends and learning which could be taken from the issues raised. We would recommend that the provider considers implementing a contemporaneous record of all complaints received covering the issues identified, how they were investigated and the outcome of such investigations. This could also include details of compliments received.

Care plans were detailed and easy to follow. Person centred information, personal choices, likes and dislikes were evident throughout. There was evidence that health needs were managed well and that people had regular access to other health services such as doctors, dieticians and physiotherapy. Following the inspection we contacted some of those professionals who had contact with Hill House and were told that staff liaised with them well, that it seemed to be a "happy place" and that they had no concerns.

Care Plans and Risk Assessments were reviewed each month by the person's key worker to ensure that they remained effective, whether changes were needed and if significant information to be considered was recorded. We would recommend that these entries detail the exact date and name of the person making the entry.

We saw that detailed risk assessments had been completed including for journeys, outside environment and bed safety rails. Weights were recorded to monitor weight loss or gain and risk was managed using a Malnutrition Universal Screening Tool (MUST). There was evidence that appropriate actions were taken when needed. The risk of pressure damage to skin was assessed using the Waterlow scale. One person had refused to have regular positional changes to help preserve their skin integrity. Their personal choice had been respected, care plan and risk assessment put in place. We saw that assessments were reviewed monthly. However, we saw that for one person the assessment had identified they were at high risk of pressure damage but this was not noted on the care plan for skin and pressure ulcer prevention.

Records included a detailed personal history, personal choices and control over daily life and preferred routines which included a detailed description of individual's preferences for example "I like to get up around 07.00", "I like to have breakfast at 08.00" and "I like to go to bed around 10.30 to 11.00".

We saw that a robust pre-admission process was in place. Staff including management, key-worker and risk assessor had visited a person as part of this process. Therefore the person was already familiar with some of the staff who were then also on shift on the day of admission. This ensured that the person felt comfortable and was warmly welcomed by staff they knew. The process also meant that staff had sufficient information to identify the support that would be needed. We saw that detailed records were in place on the day of admission including care plans, risk assessments, personal evacuation plan and that staff were already knowledgeable about the person's needs and support requirements.

Care plans included reference to the person's future wishes and evidenced that this had been discussed in a sensitive manner. We saw that some people had chosen not to be resuscitated should it become necessary. Records showed that when this was the case a do not attempt resuscitation (DNAR) form had been completed. A summary list was also retained however we found this had not been kept up to date as a person for whom a DNAR had been completed was not named. We also saw from their care file that a record noting their previous decision had not been removed and thus presented a risk that their latest decision may not be clear.

There was a rolling programme of varied activities organised by two activity co-ordinators. People told us that they felt supported to maintain hobbies and interests. One person had just returned from a trip to the Trafford Centre and another person said they regularly attended football matches. People were also able to "holiday" at other Leonard Cheshire facilities.

Details of the activities taking place, such as crafts, scrabble, shopping trip, disco and exercise morning, were posted around the building. Regular meetings took place so that people could be involved in the choice of activities. We saw that a beautician visited and observed several people enjoying the sessions taking place. Although we were told that people enjoyed the activities, staff and people said that there were not enough at weekends and evenings as the coordinators were not there. People told us that they "go out a lot".

The service had developed a well organised volunteer programme which included individual volunteers and corporate groups. Support provided included providing transport for family visits and outings, fund raising and gardening. A corporate volunteer group had recently provided the catering for a party which was attended by the local mayor and on the second day of the inspection representatives from a corporate group's accounts and sales department attended to discuss future ideas for fundraising. We spoke with a volunteer who told us that they felt Hill House was a "friendly and homely place" and that "service users are happy living here". They had recently supported someone to create a memory book and had enjoyed hearing about their life.

Requires Improvement

Is the service well-led?

Our findings

One person told us "I would say half the time the manager doesn't know what she's doing , she forgets things and doesn't prioritise" and "I wonder sometimes, it is the care manager that runs it", "Deputy Manager is very good, Manager doesn't listen". We were told that the management team operated an open door policy for staff, people using services and relatives. Some people told us that they were able to "talk to them"(management). Compliments were recorded on file such as "Managers, (Names) are excellent, always helpful".

The provider had quality assurance systems in place to measure and review the quality of the service. During the inspection the deputy manager could not locate evidence of all audits carried out therefore we asked to be provided with audit schedules and details of any audits carried out by management or by the regional management team. We received some information from the manager following their return from leave, however these, along with those previously reviewed, did not clearly demonstrate sufficiently robust managerial oversight.

The registered manager carried out a Manager's Service Health Check in August and September. We could see that some actions identified had been completed or that measures were being carried out to address. We also saw that some of the issues noted in this report had been identified, for example it was noted that supervision sessions were overdue although there was no clear plan detailed to evidence how these would be brought up to date. The September audit noted that there were no staff in need of attending refresher training however when comparing to the training matrix provided this did not appear to have been accurate.

We saw that management had carried out visits at weekend/bank holidays in April and May, both visits took place around midday. A written record was provided detailing the findings of the visit. We did not see evidence of any night visits or visits undertaken since 29 May.

Call bell response times were monitored and investigated where appropriate.

A full medicines audit was carried out in August 2017 by management. However a stock check which formed part of the audit had been carried out by named nurses therefore there was no oversight of stocks by management. In addition, the stock check verified that there were sufficient medicines to meet individual needs but there was no evidence that the stocks had been tallied with MAR charts to confirm that all medicines were present. We discussed the importance of such checks with the deputy manager particularly as there had recently been incidences of missing medicines.

Actions from audits were not always followed up, for example those noted in an audit carried out on 10 April stated that senior management would carry out an audit at least quarterly, staff supervisions would be carried out as required and an air conditioning unit would be sourced to ensure that medicines were stored at the correct temperature. None of these actions had taken place. An audit carried out by Boots pharmacy had several actions noted, some had been marked as completed however many were not. An infection control audit carried out by the manger on 28 June 2017 had sections for timescales to be set and when

completed however these had not been entered where actions were identified.

Several audits were carried out monthly by staff, for example kitchen, environment, disposal of waste and spillage. It was not always possible to identify the name of the person who had carried out the audit and most had been scored exactly the same every month with the same comments noted. We spoke with the deputy manager who agreed that some variance would have been expected. There was evidence of managerial oversight to establish the quality of these audits.

A new Service Improvement Database system (SID) had recently been implemented and we were informed that this would flag up when audits were due. .

The quality assurance processes in place were not sufficiently robust to identify the concerns noted during the inspection with regard to accident/incident management and recording.

A fire risk assessment was on file dated 11/10/16. This had an action plan included however there was no evidence to confirm that these actions had been carried out. From records provided we saw of the thirty six staff listed, nine had no recorded date for fire training. Records of fire drills were provided however not all staff had attended a drill whilst others had attended several. The records did not state the date and time of the drill nor whether correct actions had been carried out.

We discussed our concerns around records with the deputy manager and that, from the information we were able to review and direct observations, we could see that managerial oversight of care delivery and of people using services throughout the day was very good. However we had concerns about the quality of managerial governance around auditing and records. Systems were not sufficient robust to identify where quality and/or safety were being compromised. We were told that the deputy manager works three deputy shifts per week and two as a member of the care team. They accepted that there was not always sufficient time to complete audits and paperwork as required adding that "care was the priority".

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems or processes had not been established or operated effectively to ensure compliance with the regulation.

Staff told us that they felt supported, that management would listen, were approachable and fair. We were told that "(Deputy) is a good role model as a nurse".

Staff were provided with a staff handbook and had access to company policies and procedures which were located in the main office.

There was a culture that enabled people using services to be involved in the decisions about day to day life. A residents' committee has been formed with a committee chair person. People were regularly involved in decisions for example about care, improvements, meals, décor, furnishing and we were told that staff do not wear uniforms at the request of people living at Hill House.

Although most staff were unable to describe specific visions and values for the service it was clear that service user involvement and person-centred care were at the heart of the care provided. The deputy manager told us that the priorities moving forward were "care of the individual, delivering holistic care and a desire to help people lead as normal life as they possibly can".

There was evidence of effective liaison with other services including, doctor, hospital, podiatrist, optician,

dentist and continence team.

We also saw evidence of community involvement for example with the volunteer programme. A party was held to celebrate Leonard Cheshire's 100th birthday which was attended by local dignitaries and a further party to celebrate the official opening of the sensory garden is planned.

Whilst some records reviewed were detailed and fully completed others were not. For example we saw that charts to monitor fluid balance were not always completed fully. We saw that daily intake was not always totalled and there was no guidance to identify a daily intake which would be considered acceptable or not. A chart reviewed at 12.05hrs noted the last fluid intake as being 05.00hrs therefore we could not be sure that charts were being contemporaneously.

We were informed visits by the regional manager were overdue but that one was planned for the next week. Management were able to seek support from a regional management team and also from other Leonard Cheshire service managers.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure the proper and safe management of medicine.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to establish and operate effectively a system and process to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established or operated effectively to ensure compliance with this regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to

carry out the duties they are employed to perform.