Hillswood Care Limited

Hillswood Lodge

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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Hillswood Lodge on 6 October 2015. The provider is registered to provide accommodation, personal and nursing care for up to 16 older people. This includes care for people with physical needs and dementia care needs. At the time of our inspection, 13 people used the service. At our last inspection of the service on 19 December 2013, the provider was compliant with the regulations we inspected against.

The ownership of the service had changed recently and the new owners were in the process of carrying out improvements on the service. Service development plans were in place to ensure that improvements took place with minimal disruptions to the day to day lives of people who used the service and to the service as a whole.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

Summary of findings

People did not always have risk management plans in place to guide staff on how care should be provided in order to minimise identified risks. People's risk management plans were not always updated when their needs changed.

People with mobility problems were at risk of trips and falls because access within the building was not always free of obstructions.

There were not always adequate numbers of staff to meet people's individual needs. People were left unattended in lounge areas for long periods. Staffing shortages meant that staff carried out multiple roles that put people at potential risk of harm.

The provider did not always ensure that people who had been prescribed topical creams received them in order to maintain their skin integrity.

Staff did not always have the necessary training to enable them to carry out their roles effectively.

The provider did not consistently follow the guidelines of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that people were not being unlawfully restricted of their liberty. Staff did not always have a good understanding of the relevant requirements MCA and DoLS. The MCA and the DoLS set out the requirements that ensure where appropriate; decisions are made in people's best interest.

The meal time was rushed. People who suffered with dementia were not given adequate support to make choices or change their minds about what they wished to eat.

The design, adaptations and decorations of the home was not always dementia friendly. People had limited opportunities to make use of the garden and outside surrounding area independently.

People were not always supported to engage in activities they enjoyed. People were sitting for long periods of time without meaningful activities to prevent boredom.

The provider did not have effective systems in place to regularly assess and monitor the quality of services provided. Risk assessments did not always identify potential environmental risks to people who used the service.

People told us they felt safe and protected from harm. Staff understood what constituted abuse and knew what actions to take if abuse was suspected.

People told us they liked the food. People were supported to attend healthcare appointments and staff liaised with their GP and other healthcare professionals as required in order for people's health and social care needs to be met.

People told us and we observed that staff were kind and respectful. Their views about how they wished to be care for were respected. They and their relatives were involved in planning their care. There were systems in place to deal with complaints and concerns.

People who used the service, their relatives and the staff were very complimentary about the new owners of the service and the registered manager. They told us the new owners and the registered manager were always available and approachable. We observed that the registered manager had a hands-on management style. People and their relatives told us they provided feedback about services on a regular basis.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we inspect against and improvements were required. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People's risk assessments and management plans did not always provide clear guidelines as to how they would receive care and support in order to minimise the risk of harm. There were not always adequate numbers of staff to provide care. People were protected from abuse because staff were able to recognise abuse and took appropriate action when it was suspected.

Requires improvement

Is the service effective?
The service was not always effective.

Staff training was not always effective in order to support staff to carry out their roles effectively. The legal requirement of the MCA and DoLS were not always followed when people lacked capacity to make certain decisions. The environment of the home was not always suitable for people who lived with dementia. Meal times were rushed. People had access to other health professionals to ensure that their health and wellbeing was maintained.

Requires improvement

Is the service caring?
The service was caring.

People told us and we saw staff demonstrated kindness and compassion when they provided care. Staff knew people's needs, likes and dislikes and provided care in line with people's wishes. People's independence was supported and encouraged. People were supported to express their views about their care. Their views were listened to and acted upon.

Good

Is the service responsive?
The service was not always responsive.

People were left for long periods without meaningful activities. They were not always supported to engage in activities they enjoyed. The provider had systems in place for dealing with complaints. People were supported to raise complaints.

Requires improvement

Is the service well-led?
The service was not always well-led.

The provider did not have effective systems in place to regularly assess and monitor the quality of the service provided. The provider did not always ensure that people's care records reflected the care they received. Individual risk assessments did not always show how identified risks would be prevented. Service risk assessments did not always identify potential environmental risks

Requires improvement

Summary of findings

to people. People told us that the new owners of the service and the registered manager were supportive and approachable. They told us that significant improvements to the service had taken place since the ownership of the service changed.

Hillswood Lodge

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 was 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 6 October 2015 and was unannounced. Three inspectors and an expert by experience undertook the inspection. The expert by experience had personal experience of caring for someone who used this type of care service.

We reviewed the information we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding team and local commissioners of the service.

We spoke with 11 people who used the service, six relatives, two professionals who visited the service, three staff members, the registered manager and the provider.

We looked at six people's care records to help us identify if people received planned care and reviewed records relating to the management of the service. These records helped us understand how the provider responded and acted on issues related to the care and welfare of people, and monitored the quality of the service.

Requires improvement

Is the service safe?

Our findings

The provider did not always have adequate numbers of staff to meet people's needs. One person commented, "We don't see a lot of them [staff]". Another person told us they had fallen on two occasions this year and on one occasion, in the lounge but no member of staff was present. The person told us another person who used the service had called out for assistance. We noticed that there was only one call bell in the main lounge, which was not always easily accessible by people should they need urgent assistance. One person who was registered as blind was often found walking around the lounge without a staff member in the vicinity. This meant that in the event of a fall, staff would not be around to respond promptly.

We observed that people were left unsupervised in the lounge area from 09:30am until 10:15 am when the senior care assistant and care assistant were both involved in checking medications. On the day, a senior care assistant, a care assistant, a cook and the registered manager were on duty. Staff told us after that 2pm there was no cook provided and there were often two staff on duty for the evening. This meant that one staff member had to be in the kitchen to prepare the evening meal for people who used the service, leaving just one person to support people. Staff felt that people were particularly vulnerable to falls in the evening when there was only one staff member providing care whilst the other was in the kitchen. Staff also expressed concerns about staffing numbers at the weekend when the registered manager was not around to provide additional support. They felt that should there be an emergency that required two staff members, other people would be left unattended for a long period until another staff member who was on call responded.

The registered manager told us that they were involved in care provision and when they were on duty there was always someone on call in the evenings and weekends. They told us that the previous owners of the service had cut down on staff numbers to manage cost, however, the new providers had recognised the need for more staff and had approved for additional staff to be recruited.

The concerns above showed that there was a breach of Regulation 18 of the Health and Social Care Act 2008 Regulations 2014 because there were not always adequate numbers of staff to meet people's needs.

One person who was blind had experienced a serious injury following a fall at the service. The person enjoyed walking about independently within the home. The person also lived with dementia. We saw that they had experienced a number of minor accidents in the service following the initial fall. We noted that adjustments had been made to the property following the initial fall, and risk assessments had identified the areas of risks; however risk management plans were not in place to guide staff on how specific risks will be managed whilst promoting the person's safety and freedom of movement within the home.

Another person who lived with dementia and had fallen on two occasions over two months did not have risk management plans to minimise further risks of falls. We saw records of the person's falls and actions taken by staff following the falls. The person's moving and handling risk assessments had been also been reviewed following the falls, however the guidance had not been provided on how further falls could be prevented.

People who used the service and other professionals expressed concerns that the lounge area and people's bedrooms were too congested and cluttered. One person commented about many people who used the service required a Zimmer frame to walk and said this was "a nuisance" because it made walking around the home difficult for them, as they couldn't get past them. They said, "They get in my way. Whenever you want to go, they are always in front of you. You have to walk slowly. Also I sit at the back, and when they all get up at once, I have to run." A professional we spoke with raised concerns about a person's bedroom. They said it was a little bit cluttered given that the person was at risk of falls. We found that the person had fallen several times during the previous months.

We saw that there were obstructions in communal areas which placed people at further risk of trips and falls. There were several chairs in the lounge area including foot stools and tables. All those who required walking frames to assist them with their mobility sat with their walking frames in from of them thereby giving little room for manoeuvres. We saw that people getting in and out of the lounge area had to make their way around the obstacle to get to and from their chairs. Most of the people who used the service had memory problems or lived with dementia and several other were unsteady on their feet. This meant that the risk of this people having trips or fall was highly likely.

Requires improvement

Is the service safe?

The concerns above meant that there had been a breach of Regulation 12 of the Health and Social Care Act 2008 Regulations 2014 because the provider did not take adequate measure to ensure that people protected unsafe care and treatment.

People who used the service told us they felt safe and protected from harm. They told us they would not hesitate to raise concerns if they were unhappy about how they or other people were being treated. A relative said, "If I didn't think this place was safe enough, my mother wouldn't be here". Another relative told us, what made them choose the service was, "Knowing that there were so many long serving members of the home". They said they felt their relative was safe at the home. Staff were aware of how to recognise and report abuse and/or poor practice. A staff member said, I would have no problem reporting abuse and I know the manager would act on it".

People's medicines were managed safely. The senior staff member responsible for administering medications said, "[Person's name] takes time so I have to wait with them until I know they have taken it". People were supported to take their medicines in their preferred ways. One person who used the serve said, "I have my medicines first thing in the morning and last thing at night". We observed and medicine records showed that people received their medicines as prescribed. The provider had systems in place to guide staff on when and how to administer medicines meant to be given on 'as required' (PRN) basis. We saw that people's medicines were ordered and stored safely and securely.

Requires improvement

Is the service effective?

Our findings

Three people's mental capacity assessment had identified that the person had limited capacity to make certain decisions. We found that the legal requirements of the Mental Capacity Act (MCA) 2005 were not always followed because best interest assessments had not identified the types of decisions the person required support with making. The registered manager confirmed that the assessments had not been completed correctly. MCA assessments are decision specific and should only be carried out when it is identified that a person may lack the capacity to make a certain decision. We found that MCA assessments were carried out routinely for all the people who used the service.

We found that some people who used the service were subject to Deprivation of Liberty Safeguards (DoLS) for their own safety. However, we found that staff did not always have a good understanding of the principles of MCA and DoLS and what the conditions of the DoLS were. CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA and the DoLS set out the requirements that ensure where applicable, decisions are made in people's best interests when they are unable to do this for themselves.

People's dementia care needs were overlooked sometimes when care was provided. Staff had not identified how to support people with dementia when they communicated about their past as if it was current and wanted to engage in activities that which they did in the past. However, staff training records showed that all staff had completed dementia awareness training. Staff training records showed that staff had completed workbooks on specific health and social care topics on induction and then annually, and received certificates for these; however staff did not always demonstrate an understanding on how this training could be applied in their roles.

We observed that there was a choice of meal at lunch time but people who lived with dementia were not always supported to make these choices during mealtimes. This was because the meal was pre-plated and served to people. People did not have the opportunity to see what was on offer before they ate; therefore opportunities to change their minds were limited. Staff told us people were supported to make a choice of what they would like to have for lunch; however people who lived with dementia often experienced short-term memory loss and were likely to have forgotten what they had ordered earlier on in the day. A relative commented that there did not seem to be much choice with the evening meal and a lot of toast was served for tea. We checked the menu on offer for the evening meal and noted that there Tomatoes on toast, soup and cakes were on offer with no alternative. The registered manager told us that most people preferred to have bread in the evening and they would be offered an alternative if they did not like what was on offer.

The concerns above meant that there had been a breach of Regulation 11 of the Health and Social Care Act 2008 Regulations 2014 because people were not effectively supported to make decisions about their care and treatment

We observed that lunch was rushed. We observed that a staff member took one person's main meal and replaced it with a dessert when the person had only eaten a few spoons of their main meal as the person had left the table twice. We saw a member of staff spray and clean a table whilst one person was still eating their meal.

We saw that the environments adaptations, décor and the decoration of the home was not always dementia friendly. There was no pictorial signage to help with orientation and there was nothing around the home which indicated that peoples' hobbies and interests had been taken into account. The garden was not being used regularly because staff felt that it was not very safe for people who used the garden to go out unsupervised. The new owners told us they had recognised the need for the garden area to be renovated in order to make it safer and more dementia friendly. We saw that renovation work was taking place within and outside the home. One of the owners said, "We'll make the front a more secure place for people to go out on their own. We've spoke to people about colour patterns and combinations patterns to avoid". They told us the stages for which the renovations were planned for in order to minimise any disruptions to the service. This showed that there were plans for improvement.

Staff knew people's needs well. We saw that staff were attentive to people's basic care needs. The cook demonstrated a good knowledge of the people and their individual dietary needs. They had a summary of people's dietary requirements in the kitchen, which they told us they could always refer to for guidance. Most of the staff had

Requires improvement

Is the service effective?

worked at the service for several years and knew most of the people who used the service well. Staff were able to describe to us people's individual care needs and this matched what people told us and what we saw in their records and what?

We saw that people's health care needs were monitored. Staff knew who was at risk of malnutrition and who required encouragement with eating. People had their nutritional needs assessed and where people were at risk of malnutrition there was a care plan in place. People's weight was monitored and where there was significant weight loss a person had been referred to the GP and prescribed supplements. Where people required monitoring of their food and drink, intake charts were maintained for this.

A person who was at risk of developing pressure ulcers had been provided with a special mattress and cushion. Assessments were carried out and, the manager confirmed that where necessary a person would be on a turning chart in bed. We saw a special mattress in use and we saw several special pressure relieving cushions on chairs in the lounge. The manager confirmed that no one in the home had a pressure ulcer.

We saw that health care professionals visited the service regularly to ensure that people received appropriate care that met their needs. A GP visited the home regularly to review people's healthcare needs. This ensured that people maintained good health and had access to other healthcare services when they needed it.

Good

Is the service caring?

Our findings

All the people we spoke with told us they were happy in the home and felt well looked after by the staff. One person who used the service commented, “We are treated well”. Another person said, “The girls are lovely I couldn’t ask for better”. A relative said, “I looked around a lot of homes before this one and I knew straight away that this felt right. Everyone is so friendly and there is a lovely atmosphere”. Another relative said, “The staff are all lovely and they are all very welcoming.

We observed that people who used the service and their relatives were treated kindly. One relative said, “Its lovely here and just like one big family. They know just how [person’s name] likes things done. This home has got something special that other homes haven’t got”. Another relative said, “They always ask if you would like a cup of tea and we feel welcome to visit at any time.”

We saw that people and their relatives were involved in planning their care. We saw the registered manager having discussions with people and their families about various aspects relating to the care the person who used the service received. A relative said, “They let me know any changes straight away” and “I saw a group of them including[person’s name] walking to the pub for lunch the other week and I stopped and asked if I could join them and they said ‘of course you can and I did’. They are so lovely.” The manager explained that people and/or relatives are given the opportunity to be involved in care plan reviews and there is a relative’s communication record in place. A relative said, “They [Staff] always involve us in everything”.

People were treated with dignity and respect. Staff knocked on people’s doors before going in. People were well presented and dressed as they wished. One person’s care records stated that they liked to dress smartly and we saw that they were smartly dressed. People were supported to be independent. People told us they were encouraged to choose what they wished to wear and to wash and dress themselves. We saw that people were encouraged to move about within the home independently.

Requires improvement

Is the service responsive?

Our findings

People received comprehensive assessments prior to being admitted in the service and during the first few days of admission. However, there were no plans for how staff actually would support people to meet identified needs. We found that people's basic personal and health care needs were met but there was no evidence of anything over and above this. For example, it had been identified that one person who used the service enjoyed reading books, but we saw no plans in place for how that service would be supported to do what they enjoyed doing. Staff had not identified how best to support one person who regularly talked about their previous employment and constantly requested for jobs to do around the home in order to occupy themselves. The person told us, "There's not much to do here. I need to have something to take my time up". The person's initial assessments had identified that they person liked having a chat and engaging with other people but had not identified how the person will be supported to this. We asked staff how they intended to ensure that the person's needs were supported and they told us that person had not been at the service long and was still being assessed, however they had not recognised various means to keep the person occupied in order to minimise boredom.

One person wanted to pursue their interests in keeping records and sitting down to complete forms but no one pursued this with them. Another person was walking around asking to go home and there were no diversion techniques used to assist the person. One person said, "There are no trips out" and another complained of "being stuck in too much." The service had an activities coordinator who worked on set days of the week. There was no activities coordinator on the day as the activity for the day was hairdressing. We noted that everyone who was not in the hairdressers was left to sit around. Staff were not engaging in meaningful activities with people or encouraging people to engage in other activities they may enjoy.

We saw that people were not always encouraged to exercise many choices over their daily life in the home, and that there was a well-established 'routine' to which people who used the service tended to conform. One resident said "anytime you want, you can go to your room", although during the morning of our visit, all but one person who used the service was sitting in the lounges, or walking about.

People's faith belief was encouraged. People told us that a vicar visited regularly to conduct a service to people in the lounge. People were also supported to see the vicar on a one on one basis. The manager told us choristers were invited to the home to sing hymns to the people who used the service.

Some people told us that the home organises some activities they enjoyed. They told us singers came in and other entertainment sessions were put on from time to time. We saw that there was a notice on doors advertising a 'pea and pie' event in October. There was a folder containing records of activities that had taken place at the service on the days the activities coordinator was present.

People who used the service told us that that their relatives could visit at any time. The relatives we spoke with also said they were made welcome when they visited and were often offered a drink. A relative commented that they go out to local venues and they had joined the people who used the service for a meal at a pub.

People felt able to raise concerns and complaints and thought that the manager was approachable and would help them. One person told us that during a 'resident's meeting', members of staff asked them whether they had any complaints/suggestions. There was a complaints procedure displayed on the wall giving people options for making complaints.

Requires improvement

Is the service well-led?

Our findings

The systems in place to assess, monitor and improve the quality and safety of the services provided were not effective. Some people had sustained several falls at the home over short periods of time. We saw that the provider took some action following falls to ensure that risks of them reoccurring were minimised, however, control measures put in place to prevent them from reoccurring were not always effective. The provider's service risk assessment had identified that the risk of slips and trips in the home was high. Control measures had been put in place such as, "individual fall risk assessment and care plans for residents which are reviewed monthly", "removal of clutter" and "audit of accident records to identify trends or patterns". However, we found that risk assessments and plans were not always reviewed monthly, there were obstructions in communal areas that put people at risk of falls and accident records were not analysed regularly for patterns and trend. We found that the number of falls and accidents at the service had increased over a short period.

Regular audits of care records took place, however, the provider had not identified that care records did not always reflect the care people received. Care record audits had not identified that care plans did not always identify how people will be supported or how their individual care needs will be met. We noted inappropriate use of language in people's records. In one person's care record, staff had written "I [person who used the service can be very stubborn" and "I prefer to pass urine and faeces in my pad rather than use the commode" and "I [Person who used the service] am anti-social". We brought this to the attention of the registered manager.

The service had recently been bought by new owners. Staff told us they had been through a very difficult period of transition where they had received little support and finances were limited. They told us that staff morale had been low and they had just done their best to keep the service running with very little resources. Staff told us that they were now feeling very optimistic about the future. They told us the new owners had made significant changes to the service over a short period which had impacted positively on people's experiences of care. One staff member said, "The staff are very, very pleased with all the changes". Another staff member said, "We're really happy now. They're [The new owners] doing things for the home. They're actually interested. Now everyone is bouncing back because we know we've got decent owners. They're spending time getting to know the staff and the residents".

We spoke with one of the owners of the service. They said, "We're just trying to make everyone's experience better". They told us they were committed to improving the service. They told us about the improvements they had made to the service so far and shared with us future plans for the service. This showed that the provider was committed to improving services.

People we spoke with knew who the registered manager was and told us that the registered manager was friendly and approachable. One person who used the service said, "She's always around. I like her". Relatives told us that the management of the home was good and was open and inclusive. They said, "You can go to the manager about anything; [manager's name] is very approachable, as are the other staff".

Staff told us the the service was well managed and they felt supported in their job role. A staff member said, "[registered manager's name] is very good their heart is in this place, making sure the residents come first". Another staff member said, "The manager has always supported us with training". Staff members confirmed that they received regular formal supervision from the manager and there were records of this. This helped to ensure staff were supported in their role. The registered manager told us they were always available and treated the people who used the service as their relatives. They said they supported staff in care delivery too. We observed that they spent time talking with people and people could got to them at any time if they had any concerns

Staff told us they had regular supervision and staff meetings. A staff member commented, "I can always go to [registered manager's name] if I wasn't happy with anything". We saw records that demonstrated that staff received regular supervision. Minutes of staff meetings showed that key issues around care provision were discussed and actions put in place. This showed that the provider promoted an open and inclusive culture within the service.

Requires improvement

Is the service well-led?

The provider submitted notifications such as notifications relating to the death and injuries of people who used the service. It is a registration requirement for providers to notify us of such events. Other conditions for the provider's registration with us were being met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not effectively supported to make decisions about their care and treatment.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because people did not always have appropriate risk assessments and management plans in place.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not adequate numbers of staff to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.