United Health Limited

Hill House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 February 2017. After that inspection we received two notifications of incidents following which two people using the service died. As a result we undertook a focused inspection on 21 February 2018 to look at how people were being cared for. This report only covers our findings in relation to the key questions of 'Safe', 'Caring' and 'Well-led'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hill House Care Home on our website at www.cqc.org.uk

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

Hill House Care Home can accommodate up to 23 people with a learning disability, autistic spectrum disorder and physical disabilities. On the day of the inspection, there were 14 permanent people present, one person was visiting their relatives and four people were receiving respite care.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had a manager that had been in post since September 2017. They told us they were in the process of submitting their registered manager application. We will monitor this. 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.

The provider had systems and processes in place to support staff to act on any safeguarding concerns. Where safeguarding incidents had occurred, the provider had taken appropriate action to investigate these. This included following staff disciplinary procedures.

Staff did not always have sufficient information about risks associated with people's needs and how these should be managed. Staff had not always adhered to people's risk assessments as required. Risks to the external environment had not been appropriately assessed or planned for.

Some concerns were identified with the deployment of staff and training gaps were identified in staff training. Safe staff recruitment checks were in place.

Some shortfalls were identified in the management of medicines, the manager had already identified these,

and action was being taken to make the required improvements.

Staff were aware of the measures required in the prevention and control of infections and the service was found to be clean.

Staff were kind and caring and had developed positive relationships with people who used the service. Dignity and respect overall was shown towards people.

Independent advocacy information was not available. However, the manager showed knowledge and understanding of the importance of people having access to this information and agreed to provide this. People knew about their care plans and felt involved in discussions and decisions about their care.

The systems and processes in place to monitor quality and safety had not identified all the shortfalls identified during the 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.

Systems and processes were in place to keep people safe from potential abuse.

Information available for staff of how to support people with known risks was either limited or not followed. The external environment required a risk assessment.

Some concerns were identified with staff deployment.

Safe staff recruitment checks were in place.

Shortfalls with medicines had already been identified and action was being taken to address these.

Processes were in place to manage the prevention and control of infection and the service was clean.

Is the service caring?

Good

The service was caring.

People were cared for and supported by staff who respected them as individuals and who knew them well.

People and their relatives were involved in discussions and decisions about their care and support.

Staff had developed positive relationships with people. They respected their privacy, dignity, and prompted independence.

People did not have access to independent advocacy information but the manager agreed to provide this information for people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The systems in place to check and monitor the quality and safety

of the service were found not to be fully effective.

People and their relatives did not receive opportunities to give their views and experience about the service.

People who used the service, relatives and staff were positive the manager was supportive and approachable.

Hill House Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by two separate notifications of incidents following which two people using the service died. The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls, epilepsy and the measures in place to check on people's safety and well-being.

The coroner was informed of both deaths.

This inspection took place on 21 February 2018 and was unannounced. The inspection was completed by two inspectors, a specialist advisor who was a registered mental health nurse 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.

Before the inspection, we reviewed information that we held about the service such as notifications, these are events, which happened in the service that the provider is required to tell us about. We also considered the last inspection report and information that had been sent to us by other agencies. We also contacted commissioners (who fund the care for people) of the service and the local authority safeguarding team.

On the day of the inspection visit, we engaged with ten people who used the service about their experience about the care and support they received. Due to some people's communication needs, their feedback about all aspects of the service they received was limited in parts. We also used observation where appropriate. This was to help us understand people's experience of the care and support they received. We contacted a relative via telephone and spoke with a further two relatives after the inspection for their views about the service their family member received. We also spoke with a visiting district nurse.

During the inspection, we spoke with the manager, compliance manager, two senior care workers, two care

workers, an activity coordinator and a housekeeper. We looked at all or parts of the care records of six people along with other records relevant to the running of the service. This included the management of medicines, quality assurance audits, training information for staff, recruitment and deployment of staff and staff meeting minutes.

After our inspection, we also spoke with the provider's director.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's needs had been assessed and planned for. However, information to support staff of the action required to manage known risks, either lacked clear detailed information or were not always followed by staff.

For example, one person was at risk of developing pressure ulcers. To reduce this risk the person had a pressure relieving mattress and seat cushion in place. We were aware from speaking with a visiting district nurse the person had a skin moisture lesion. As part of the management of this, the district nurse had requested the person be repositioned every two hours. The person's daily notes stated staff should follow the district nurses recommendations but did not record what these were. The person's wound care plan had not been updated to inform staff of the recommendations made by the district nurse. We asked staff about their understanding of the person's repositioning needs and found two out of three staff were unaware of what the frequency was of repositioning. The person had a reposition chart in place that showed the person had not been repositioned at the frequency required. Records showed seven days prior to our inspection that repositioning varied between two, three and six hours with the longest time between repositioning being from 5.30am to 10.50pm. Whilst shortfalls were identified in the person's care, the district nurse told us the person's skin was healing and had not deteriorated.

We reviewed the care plans for people who had a diagnosis of epilepsy. Information to support staff to understand the type of epilepsy seizure the person could have, how this may present, what staff should do post seizure, lacked information and instruction. However, staff showed an understanding of people's needs. The manager was aware of the shortfalls in information and had started to review care plans and risks assessments. We viewed an example of a person's care file that had been reviewed and updated and this was found to be more supportive to staff. Included was clear information of the observations required of staff to check on people's safety.

A person who had epilepsy had a monitor in place to alert staff to sounds that may indicate the person was having an epileptic seizure whilst in their bedroom. However, the monitor sounded in a communal lounge where staff were not located at all times. This method to alert staff was therefore ineffective and placed the person at risk of having a seizure and not receiving support from staff in an emergency situation. We discussed this with the manager who agreed to seek external advice about a more appropriate system to use.

Three people used wheelchairs with lap belts to support their safety. We asked the manager if a risk assessment had been completed because this was a restriction, which may have affected their safety and comfort. The manager said there was no risk assessment in place for staff to check the lap belt for safety and comfort. However, the manager told us checks were completed but not necessarily recorded.

Another person had a risk assessment to support them to chop wood, their favourite pastime. It was evident consideration had been given to not put undue restrictions on the person. However, the risk assessment clearly stated staff needed to check the environment was kept safe, such as equipment being stored safely.

We found the area was cluttered with tools lying around. We observed a pair of safety goggles hung on the wall. The person indicated what they were for by rubbing their eyes. These goggles were extremely dusty and broken suggesting they were not used and had not been for a long period. This meant the person was being placed at risk of injury.

The risk assessment also stated staff were required to regularly check on the person when they were working in the shed. During the course of our inspection, we saw the person frequently leave the service to go to the shed that was located at the bottom of the garden. Only on one occasion was a staff member seen to ask the person where they were going. We did not observe any staff check on the person as directed in the risk assessment. This was a concern, as staff were not following instruction. We were aware of the person experiencing a fall during 2017 when they sustained a fracture. This meant the risk assessment had considered potential risks that needed monitoring and staff were not always following this.

Some people experienced periods of anxiety that could affect their mood and behaviour. One person preferred to spend their time in their bedroom, often choosing to remain in bed. We were aware from external professionals that this behaviour was a concern due to the risk of self-isolation. We saw in this person's social support care plan some intervention strategies to support the person. However, this information was very limited. For example, the care plan stated a 'count down chart was sometimes used' but there was no explanation as to what this was and how it worked. A staff member explained how it worked; it was an approach to prepare the person in advance to the support that was going to be provided. However, the staff member said not all staff used this approach, which impacted on the person's mood and refusal to get up and engage with others or participate in activities.

Systems were in place to check on the premises and environment. However, we noted some potential safety issues relating to the external environment that may have posed a safety and security risk to people. For example, there was open access to a nearby road. The management team told us that they did not consider there to be any risks to people. However, they did agree that a risk assessment had not been completed and agreed to complete one.

Some people who used the service and relatives raised some concerns about staffing. One person said, "I have to wait for help for when they (staff) have finished doing other things." Another person said, "I wait a long time for help." One relative said, "There is enough staff but they could always do with more." Another relative told us their only concern was around staffing levels. They told us they visited their family member regularly and during visits they had to frequently go and find staff.

Staff told us they had concerns about staffing levels and felt an additional staff member was required. One staff member said, "There's not enough time to spend with people, some need two staff to support them at times, I think people are safe but it's about quality."

Some people were totally reliant on staff for all their care, comfort and safety needs. The layout of the building meant it was difficult for staff to observe communal areas all of the time. In another room, we saw a person rocked in their wheelchair with such force the front wheels came off the floor but no staff was present to check the person was safe. We observed two staff sat at the dining table competing records for 45 minutes. A staff member said this happened three times a day. This showed staff were more task centred in their approach to care and support. This also highlighted an issue with the deployment of staff.

The management team told us they assessed people's dependency needs in December 2017 and felt the staffing levels were sufficient. They added that all staff across the service could provide support to care staff in the supervision of people, during periods when care staff were busy. This included the cook, housekeeper

and equestrian staff member (attached to the service were horse stables). The training plan showed not all staff had received training that sufficiently supported them to provide safe and effective supervision of people who used the service. For example, not all staff had completed refresher training in safeguarding and moving and handling. There was a significant amount of staff who had not completed training in learning disability awareness and autism awareness. We discussed this with the management team; they agreed to review staff's training needs to ensure all staff were sufficiently trained. The management team also agreed to review the deployment of staff.

People who used the service and relatives confirmed they felt staff protected them from abuse and avoidable harm. Comments included, "Yes, I feel safe here." "I have no concerns about [name of family member]'s safety." People had access to safeguarding information provided in an easy read format to support their communication needs. This supported people to understand their rights and how to raise safeguarding concerns.

Staff were clear about their role and responsibility of protecting people. This included harassment and discrimination in relation to the protected characteristics under the Equality Act. They told us they would report concerns about a person's safety to the senior or manager and they would expect them to take appropriate action. In addition, staff added that they could and would contact CQC or the local authority safeguarding team if they were not satisfied with the outcome taken by the management team.

The provider had ensured staff received training in safeguarding adults and a safeguarding policy and procedure was available to inform staff practice. Records confirmed where safeguarding concerns had been identified in relation to poor or unsafe staff practice. This had been responded to and action taken to mitigate any further risks. This included implementing the provider's staff disciplinary procedures.

Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people. This included criminal record checks and employment history.

People who used the service and relatives raised no concerns about how medicines were managed. We observed people received their medicines safely and staff followed best practice guidance. We checked the systems and processes in place for the safe management of medicines. We identified some shortfalls that the manager was already aware of and was taking action to address. Body maps were required for the use of topical creams to clearly instruct staff of the site application. Information about people's preferences of how they took their medicines required further detail. Protocols in place for medicines administered 'as and when' needed further information and guidance for staff. Medicines were stored safely and a sample stock check was found to be correct. Staff responsible for the administration of medicines had received appropriate training and the provider had a medicines policy and procedure to inform practice.

The service was found to have good standards of cleanliness and hygiene. The provider had a prevention and control of infections policy and procedure based on best practice guidance. Staff had received appropriate infection control training and were aware of action required to manage any risks. Cleaning schedules were in place and found to be up to date and provided housekeeping staff with guidance of what was required to maintain good standards of cleanliness.

The provider had systems and processes in place to manage accidents and incidents. Staff were aware of their responsibility to respond to any incident or accident. The manager was responsible for reporting accidents and incidents to senior managers to show what action had been taken to mitigate further risks. The manager told us they were aware that improvements were required to analyse accidents and incidents including falls. The manager said they needed to consider if there were any themes and patterns to learn

from. The current analysis did not go into this level of detail.

Good

Is the service caring?

Our findings

People who used the service were positive about the caring approach of staff. One person said, "They (staff) are kind and helpful. I feel comfortable with the staff. I say ten out of ten for here." Another person said, "The night staff are kind especially one. I would tell them (staff) off if they did things wrong when they helped me. I choose ladies to help me not men. I've got a care plan (pointed to office)."

Relatives were also complimentary about the staff in providing their family member with good care. One relative said, "The staff are kind, well amazing. I talk to the staff and find it easy to approach them. They always make time for me." Another relative said, "The staff are very good but good ones don't always stay. Staff are very in tune to how [name of family member] works."

Staff spoke kindly and with care and compassion about the people who lived at the service, clearly demonstrating they had formed positive equal relationships with people. One staff member said, "I love this place. It's like one big family." Staff told us they worked well as a team. One staff member said, "Staff make the place with the trust and connection with each other. All are sensitive to people's changing needs. They pick up on 'upsets; etc.'." (Referring to any changes to a person's mood and behaviour).

Some people showed us their bedrooms and these were found to be personalised to individual needs and tastes. We visited a person in their bedroom; the room was very individual to them and had on display memorabilia about their favourite Premiership football team. Rock and Roll music was playing loudly and the person was clearly enjoying this as they were tapping their feet and dancing in their chair. We observed staff calling into the person to check on them and saw how they joined in with the singing and dancing, to which the person showed their enjoyment by smiles and laughter.

Our observations of staff engagement showed people were relaxed and comfortable in the presence of staff. Light-hearted jovial exchanges were made that were comfortable and relaxed. During the inspection, we observed people were offered different opportunities to participate in activities. One person went out to a community day service. One activity coordinator took two people on a community activity and the second activity coordinator encouraged people to participate in a baking session in the morning. We observed people enjoyed this activity; they were chatting and joking together. The member of staff that led the session was very enthusiastic and this appeared to support people with their enthusiasm as well. We later saw the same member of staff support and encourage some people to play a board game People appeared to be very happy and laughing together.

Some people required assistance with eating and drinking and staff were observed to support people with patience and attention. Staff told us there was a flexible approach to mealtimes and this suited people's needs and preferences.

People told us they received opportunities to discuss their care and support needs, they were aware of their care plans and had access to these if they wished. One person said, "Sometimes we have meetings and they (staff) would change things if I asked them."

Relatives also told us they were confident their family member was involved as fully as possible in their care. One relative said, "My relative is included in as much as they can. They are very comfortable at Hill House and are always eager to get back after a home visit. They have favourite friends and care staff."

People did not have direct access to independent advocacy information. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. However, the manager gave examples of how people would be supported to access this support, showing an understanding and commitment of the importance of this support for people. The manager assured us they would source this information and make it available for people.

We saw some examples of staff respecting people's dignity and respect and offering choices of activities. For example a staff member supporting a person to change their clothing was overheard to say, "Which colour trousers shall we choose?" The staff member used good communication and listening skills. The gestures and soft voice used by the staff member was comforting to the person. It was a pleasing exchange with respect and dignity maintained. We also saw two examples where staff showed a lack of dignity and respect and we discussed this with the manager who took immediate action and addressed this.

People's personal information was stored securely and staff were aware of the importance of confidentiality. The registered provider had a policy and procedure that complied with the Data Protection Act.

People's friends and relatives were able to visit them whenever they wanted to. Staff confirmed this and told us people's relatives and friends were able to visit them without any unnecessary restriction.

Requires Improvement

Is the service well-led?

Our findings

During the inspection, we identified some shortfalls in the systems and processes in place to check on safety and quality.

Action to mitigate risks had not always been completed effectively and this had not been identified in the systems in place to monitor the quality of the service. For example, people's care plans and risk assessments were found to lack specific detail in places. This lack of clear documented instruction and guidance for staff meant there was a potential risk to people's safety and welfare.

Whilst new handover and communication systems had recently been implemented, there were shortfalls found in how staff were informed of how to support a people with their needs. Where healthcare professionals had made recommendations, this had not been clearly recorded or handed over to care staff by the management team.

Some people had specific needs in relation to their anxiety that affected their mood and behaviour. We identified the behavioural strategies in place for one person lacked detail, meaning staff did not provide a consistent approach. This impacted on the person's well-being.

Accidents and incidents were recorded but there was no analysis to understand and consider patterns and trends. From viewing care records, we could not be assured that action had always been taken to reduce the risks of reoccurrence. The management team were confident the external environment was safe for people, but they had not completed a risk assessment to demonstrate how they had concluded this.

The management team told us they considered staffing levels were sufficient in meeting people's individual needs and safety. They said this was because non-care staff across the service could support staff at busy periods in the supervision of people. However, the staff training plan showed there were some training gaps for non-care staff that could compromise people's safety.

The manager had identified some training needs such as medicines training and was addressing this. However, additional gaps were found, which the manager had not identified. Some people were at risk of skin damage but only one staff member had received training in tissue viability (skin care and risks). Not all staff had completed refresher training in safeguarding and moving and handling. There was a significant amount of staff who had not completed training in learning disability awareness and autism awareness. Staff meetings, supervision and appraisal meetings, and opportunities for staff to discuss their work, training and development needs were found to be infrequent. Staff confirmed this and from viewing staff files, there was no obvious process of planned ongoing supervision or appraisals.

The manager told us about the audits and checks they completed daily, weekly and quarterly. We also reviewed the compliance manager's latest audit visit report dated January 2018. These records confirmed areas that required improvement identified during this inspection had not all been picked up by the systems in place. There were no regular meetings for people who used the service, or surveys used to gain people's

experience about the service. This meant people had limited opportunities to be involved in the development of the service or to give their views on the quality of the service.

This shows a lack of governance of the service and is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service, relatives and staff reflected on the building being in need of refurbishment. Our tour of the building also found the service was in need of improvements throughout. The management team shared their 2017 refurbishment plan that identified what improvements had been planned. The action plan advised that some of the work was due to commence imminently. Following the inspection, the provider's representative informed us some improvements had already been completed. This included new windows, new facia boards and guttering, new commercial kitchen, complete refurbishment of two bathrooms, plus the installation of an extra shower facility. In addition, two bedrooms had en-suite facilities installed to meet people's needs, front of house painted, raised planters built, rewiring electrical work, refurbishment of the activity lounge.

The registered provider was aware of their responsibilities as part of their registration with the CQC to ensure we were informed of any reportable incidents. These include reporting serious injuries, allegations of abuse and events that could stop the service running appropriately. The ratings for the last inspection were displayed on the provider's website and at the service.

The staff team spoke positively about the manager's leadership style. They told us the manager was supportive and approachable. We found the manager to be open and transparent they showed a commitment in making the required improvements and gave us some examples of how they planned to achieve this. An example was given of their approach to developing people's care plans. Whilst they had commenced a review they needed to prioritise these to ensure people with the greatest needs had their care plans and risk assessments reviewed first.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess the quality and safety of the service and monitor against risks relating to the health, safety and welfare of people who used the service. Regulation 17 (1)