Dolphin Property Company Limited

Hillcrest Care Home

Inspection report

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26 July 2016

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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 21 July 2016 and was unannounced. This meant that the provider and staff did not know that we would be visiting. We carried out further announced visits on the 23, 25 and 26 July 2016 to complete the inspection.

We last carried out an inspection in September 2015, where we found a continuing breach relating to the condition and safety of the premises. We issued a warning notice and told the provider that they must take action to improve. We also identified breaches in regulations 11 and 17, relating to the need for consent and good governance.

At this inspection we found that action had been taken in these areas, however further action was required with regards to the premises.

Prior to our inspection in July 2016 we received an anonymous concern about the environment, infection control and staffing levels at the service. We took this information into account when we were planning our inspection.

Hillcrest Care Home provides care to a maximum of 52 older people, including those with a dementia related condition. There were 38 people living at the home at the time of the inspection

There had been a change in the provider's management structure. A new management company called Careport had taken over the management of the service on 11 July 2016. Careport manages care homes across the UK on behalf of their owners.

We spent time looking around the service and saw that a full refurbishment of the home had taken place. Careful consideration had been given to ensure that the environment met the needs of people with a dementia related condition. Previously, the dementia care unit and nursing units were spread across two floors. Now, each unit was located on a specific floor; the dementia care unit was located on the ground floor and the nursing unit was on the first floor. We found however, that the nurse call and fire alarm system did not correspond to the new layout of the home. This meant there was a risk that people may not receive care in a timely manner and the location of a fire could not be identified by staff. The manager had put in place contingency arrangements in relation to these two issues. She told us that these were being addressed the week after our inspection. We passed our concerns to the local authority and fire safety officer. Following our inspection, the manager confirmed that the fire alarm and nurse call systems were now fully operational.

Some of the front covers on the radiators were broken and hanging off which was a health and safety risk. We checked equipment at the service and found that equipment for certain clinical tasks was not always available.

We checked how people's nutritional needs were met. Most people and relatives said that meals could be improved at the home which was confirmed by staff. We observed the lunch and tea time periods and saw that although staff were attentive to people's needs, meals did not always look appetising and we observed that one meal which had been prepared for those who required a blended diet was not suitable because it contained lumps of potato. We examined the menus and noticed that there was no choice for those who required a soft or blended diet.

Following our inspection, the manager told us that the menus had been changed and positive feedback had been received about the improvement in the meals. In addition, they were receiving support from the local NHS trust's dietetic team.

There was a registered manager in post. She became registered with the Commission in May 2016. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Most people, relatives and staff were positive about the manager. One staff member said, "I find her really supportive." Several staff and a relative told us that they did not like her management style.

We received mixed comments about whether there were sufficient staff on duty. Most people told us that staff met their needs in a timely manner. However, two people and several relatives said that more would be appreciated. Most staff said that more staff were required. A staffing tool linked to the dependency of people who lived at the home had not been carried out at the time of the inspection to ensure that staffing levels met the needs of people who lived there. Following our inspection, the manager told us that she was now completing a staffing tool which showed that they were staffing the home above the recommended levels. She also said she had deployed an extra care worker on the nursing unit on most days.

We checked recruitment procedures at the service. Staff told us and records confirmed that checks were carried out before they started work at the service.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. We spoke with a local authority safeguarding officer who told us that there were no organisational safeguarding concerns regarding the service. People's medicines were managed safely.

The manager provided us with information which showed that staff had completed training in safe working practices and to meet the specific needs of people who lived at the service, such as dementia care training.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals." We found that the provider had taken action to improve in this area and the manager had now submitted DoLS applications to the local authority to authorise in line with legal requirements. We found that further improvements were required however, to ensure there was documentary evidence to demonstrate how the requirements of the MCA were met.

There was a complaints procedure in place. Feedback systems were in place to obtain people's views. Meetings and surveys were carried out. The manager informed us that they had not received the analysis of the 2015 survey feedback from the provider.

We identified shortfalls during our inspection. These related to the premises, the assessment of staffing levels, meeting people's nutritional needs and evidencing of the MCA. Although audits had highlighted some of these issues such as concerns regarding the fire alarm and nurse call systems, action was not always taken in a timely action to address these.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the premises and equipment and meeting nutritional and hydration needs. You can see what action we told the provider to take at the back of the full version of the report.

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

Not all aspects of the service were safe.

Some of the front covers on the radiators were broken and hanging off which was a health and safety risk. Equipment for certain clinical tasks was not always available.

We received mixed comments about staffing levels during our inspection. Following our inspection, the manager told us that staffing levels had increased and staffing levels had been assessed.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Meals were not always suitable to meet people's needs and preferences.

Further improvements were required to ensure there was documentary evidence to demonstrate how the requirements of the MCA were met.

Staff told us that training courses were available in safe working practices and to meet the specific needs of people who lived at the service.

People had access to a range of healthcare services.

Is the service caring?

Good

The service was caring.

People and relatives told us that staff were caring. We saw positive interactions between people and staff.

People and relatives told us and our own observations confirmed that staff promoted people's privacy and dignity.

We saw that staff knocked on people's doors and spoke with people in a respectful manner.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which detailed the individual care and support to be provided to people.

An activities coordinator was employed to help meet people's social needs.

There was a complaints procedure in place. Feedback systems were in place to obtain people's views. Meetings were held and surveys carried out.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

We identified shortfalls during our inspection. These related to the premises, the assessment of staffing levels, meeting people's nutritional needs and evidencing of the MCA. Although audits had highlighted some of these issues such as concerns regarding the fire alarm and nurse call systems, action was not always taken in a timely manner to address these.

A registered manager was in post. There was currently no clinical lead in place to oversee the clinical aspects of the service.

Hillcrest Care Home

Detailed findings

Background to this inspection

The inspection took place on 21 July 2016 and was unannounced. This meant that the provider and staff did not know we would be visiting. We then carried out a further three announced visits on 23, 25 and 26 July 2016. The inspection was carried out by one inspector.

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.

Prior to carrying out the inspection, we reviewed all the information we held about the home including any statutory notifications that the provider had sent us. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We also reviewed information and feedback which had been posted on a national care homes review website. We took this information into account when planning our inspection.

We did not request a provider information return (PIR) prior to our inspection. A PIR is a form which asks the provider to give some key information about their service, how it is addressing the five questions and what improvements they plan to make.

We displayed posters at the service to inform people, relatives and visitors that we were inspecting Hillcrest Care Home and invited them to share their views.

We spoke with 12 people and 12 relatives. We attended a relatives' meeting which was held on Saturday 25 July 2016. We conferred with a community matron for nursing homes, a reviewing officer, a continuing health care nurse assessor, a food and health worker/nursing home trainer co-ordinator from the local NHS trust, a challenging behaviour practitioner from the local mental health trust, a prescribing advisor for elderly care and a pharmacist technician from the medicines optimisation team, a safeguarding officer, a contracts officer and a fire safety officer from the local authority.

We spoke with the registered manager; two senior care workers, six care workers, an activities coordinator and the cook. We also conferred with a hygiene and food consultant who the provider had asked to support staff at the home. We read four people's care records and two staff recruitment files and details of staff training. We looked at a variety of records which related to the management of the service, such as audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2015, we identified shortfalls in the premises and equipment. In addition, we had concerns with certain infection control procedures.

Prior to our inspection in July 2016 we received an anonymous concern about the environment, infection control and staffing levels. We took this information into account when we were planning our inspection.

At this inspection we spent time looking around the service and saw that a full refurbishment of the home had been completed. New flooring had been laid throughout the home and bathrooms had been fitted with assisted baths and shower units. Due to the age of the building, we noticed that although new flooring had been laid, some of the floor boards underneath were slightly uneven. The manager told us that she would complete a risk assessment with regards to this issue. Some of the front covers on the radiators were broken and hanging off which was a health and safety risk.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to premises and equipment.

We checked equipment at the service and saw that tests and checks had been carried out to ensure equipment was safe and suitable. Staff told us that they required a new piece of clinical equipment. We spoke with the manager about this and she told us that she had ordered this.
Previously, the unit for people with a dementia related condition and the nursing unit were spread across two floors. Now the unit for people with a dementia related condition was located on the ground floor and the nursing unit was on the first floor. The manager told us, "It's fabulous, it enables staff to provide a quicker response, they aren't spending time going up and down stairs. It also makes sure that staff are more readily available to people."

We found however, that the nurse call and fire alarm systems did not correspond to the new layout of the home. This meant there was a risk that people may not receive care in a timely manner and the location of a fire could not be immediately identified by staff. The manager had put contingency arrangements in place to lessen the risk caused by these two deficits. She explained that if the fire alarm sounded, staff would immediately phone the fire brigade and not place themselves at risk by trying to locate the source of the fire. She told us that the fire alarm and nurse call systems were being addressed the week after our inspection. We passed our concerns to the local authority and fire safety officer.

Following our inspection the manager told us that the nurse call and fire alarm systems were now fully operational.

Staff explained that the nursing unit was divided by a door with a keypad. They explained that this was a hindrance since they had to keep entering the code and it was difficult to see what was happening on the other side. One staff member said, "It would be so much better if that door was open. You have to stop and put the code in each time and if you're carrying things, it just slows you down." The manager told us that this

was being addressed.

We checked infection control procedures. Staff told us, and our own observations confirmed, that staff had access to personal protective equipment such as gloves and aprons. We saw all areas of the home were clean, and there were no malodours in any of the communal areas or bedrooms we checked. There had been no infectious outbreaks in the previous 12 months. 100% of staff had completed infection control training. There was an infection control champion in place. This meant there was a dedicated member of staff who oversaw infection control systems and practices to ensure that the correct procedures were followed.

We checked staffing levels at the home. We received mixed comments from people and relatives about whether there were sufficient staff on duty. One person said, "I think there are enough staff although according to the staff there are not enough of them." However, another person said, "The staffing levels are not high enough." A third person said, "We have to wait for everything." A relative told us, however, that she considered that more staff were required and personal care was not always provided in a timely manner."

Staff told us that more staff would be appreciated. One staff member said, "It's not just about numbers, it's about dependency. Many of the residents need prompting or persuading which takes time. You always have to take a gentle approach and I think we should have more staff."

We saw that staff generally carried out their duties in a calm unhurried manner. We did not observe any occasions where people's needs were not met and people appeared well cared for. Attention had been paid to people's presentation. Staff had ensured that people's glasses were clean and their nails were manicured.

A staffing tool linked to dependency levels of people who used the service had not been completed at the time of the inspection to ensure that there were sufficient staff deployed to meet people's needs. Following our inspection, the manager told us that she had now completed a staffing tool which showed that they were staffing the home above the recommended staffing levels. She said she had also deployed an extra care worker on the nursing unit.

Staff told us that the correct recruitment procedures were carried out before they started work. We saw that Disclosure and Barring Service (DBS) checks had been obtained. A DBS check is a report which details any offences which may prevent the person from working with vulnerable people. They help providers make safer recruitment decisions. There was only one written reference in one of the recruitment files we viewed. The manager was aware of this issue and explained that there had been a delay in receiving the second reference. The manager told us that this staff member was currently on their induction and were working in a supervised capacity at all times. We saw that one person's reference was from an employer who wasn't listed on their employment history. The manager said that she would look into this.

We checked the management of medicines. The local authority had raised some concerns with the recording of medicines and had organised for a care homes pharmacy technician to provide support in this area. We spoke with the medicines optimisation team's prescribing advisor who said, "We didn't feel there was anything urgently wrong and we have given them [staff] some guidance and advice about what they could do."

We checked seven people's MARs and did not see any gaps in the recording of medicines. We noted that staff had checked and double signed all handwritten entries to ensure accuracy. The manager told us that they were changing pharmacy suppliers because of issues with their current supplier. We found that there was a safe system in place for the receipt, storage, administration and disposal of medicines.

People told us that they felt safe. Comments included, "Oh yes I feel safe" and "Everyone in here gets along. The staff are good, there is no backbiting, no one falls out with anyone." There were safeguarding policies and procedures in place. Staff had completed safeguarding training and were knowledgeable about what action they would take if abuse was suspected. One member of staff said, "I would always report anything suspect, not that I've seen anything. I would be happy for my mum and dad to be cared for here." The manager told us that there were no ongoing safeguarding issues. This was confirmed by the local authority safeguarding officer who told us that there were no organisational safeguarding concerns regarding the service.

There were assessments in place where people had been identified as being at risk. They described the actions staff were to take to reduce the possibility of harm. Areas of risk included falls, moving and handling, malnutrition and pressure ulcers. These had been reviewed and evaluated regularly.

We noted that accidents and incidents were recorded and analysed. This procedure helped to ascertain if there were any trends or themes, so that action could be taken to help prevent or reduce the likelihood of any further incidents. Action was taken if any concerns were identified. Those who fell frequently had been referred to the falls clinic or other specialists such as the Parkinson's disease nurse or an occupational therapist for advice. The manager told us, "We do look at everything. Our company policy is that we have to refer on to the falls clinic if a person has two falls or more over one month."

Requires Improvement

Is the service effective?

Our findings

We checked how people's nutritional needs were met. Most people and relatives told us that meals were not always appetising and felt that improvements were required. Comments from people included, "The biggest gripe is the food," "The food is not very palatable," "The surroundings and staff are very good, it's just the food" and "The food is bland, the vegetables are boiled to death and there's no herbs and no taste, it's the worst part about living here." A relative said, "I think the meals are institutionalised." Another said, "The food looks so bland…there's not a good choice. Meal times are one of the most important parts of the day, it's what people look forward to and they should be getting it right."

We read the minutes of a staff meeting which was held on 28 June 2016. These stated, "Food remains an issue. Feedback from the meeting was again saying that there was not enough seasoning in the food that was served and the vegetables were watery and overcooked." We also looked at the minutes from the 'residents steering committee meeting' from the 20 July 2016. These stated, "The food and the quality of what is being served was discussed. Feedback had been variable of late. Previous issues with the food was around the vegetables being soggy and the frequency of chicken on the menu. These have both been addressed."

We examined the three weekly menus and noticed that there was an emphasis on bread based meals at tea time. These included baked beans on toast, pilchards on toast and sandwiches.

We checked the provision of meals for people who required a soft or blended diet. Staff explained that there was no separate menu or choice for those who required a modified textured diet. We observed the tea time meal which had been prepared for those who required a blended diet. This consisted of chicken in a white sauce topped with lumpy mashed potato. This looked bland and unappetising which was confirmed by two staff who tasted it on the instructions of the manager. The manager explained that the mashed potato should not be lumpy because it was a choking risk. We passed our concerns to the local community dietetics team.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to meeting nutritional and hydration needs.

An external hygiene and food consultant was supporting staff at the home. She explained that she was checking food hygiene practices and delivering training. Following our inspection, the manager told us that new menus were in place. The manager had also contacted the community dietetics team and they were providing additional advice and training.

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

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our previous inspection we found that staff had not completed DoLS applications for people who lived on the nursing unit. We also found there was a lack of documented evidence to demonstrate that care and treatment was given in line with the Mental Capacity Act 2005.

At this inspection the manager had submitted DoLS applications to the local authority to approve in line with legal requirements. We found that staff followed the principles of the MCA and acted in people's best interests, however records were not always available to demonstrate this.

We recommend that records should evidence that care and treatment is always sought in line with the Mental Capacity Act 2005.

People told us that staff asked for their consent before carrying out any care or treatment. This was confirmed by our own observations. We saw staff asked people for their consent before delivering any care. We talked with staff who demonstrated they were aware of the importance of involving people in decisions and listening to their views about what they wanted.

People were complimentary about the effectiveness of staff. Comments included, "They know what they are doing" and "Yes I think they are well trained, they have certainly had the basic training." Relatives were also complimentary about staff. One relative said, "The staff are phenomenal…I spoke with all staff and asked them about their qualifications. There wasn't one who wasn't trained." Another relative said, "I've heard them talk about all the training they've done, they've been through all their levels [vocational training]." Many of the staff group had worked at the service for a considerable period of time. This experience contributed to the efficiency and skill with which staff carried out their duties.

All staff informed us that they felt equipped to carry out their roles and said that there was sufficient training available. Comments included, "I'm up to date with all my training," "The e-learning is really good, I like it because it puts you in control" and "The moving and positioning training was really relevant, it was very practical."

The manager provided us with information which showed that staff had completed training in safe working practices. This included safeguarding adults, health and safety, first aid and moving and handling. Staff had also completed training to meet the specific needs of people that lived there. We read that 100% of staff had completed 'dementia awareness' and 'understanding and managing behaviour that challenges' training. We looked at the minutes of a staff meeting which was held in May 2016; these stated, "Thank you to everyone who has completed the new course. Our overall statistics are at 95%." The manager told us, "I think the better skilled and trained we are, the better care our residents get."

We spoke with the community matron for nursing homes. She told us that she had delivered clinical training to the staff including venepuncture [taking of blood], verification of expected death, catheter care and training on the use of syringe drivers [a small pump which releases a dose of pain killing medicine at a constant rate]. One of the nursing staff told us, "[Name of community matron] is wonderful, she is a great support both to us and the residents…She has done training on sub cut [subcutaneous] fluids and sessions on venepuncture."

Staff told us and records confirmed, that they undertook induction training when they first started working at the home. This meant that staff felt prepared when they started working independently at the home and

supported the effective delivery of care.

Staff said they felt well supported. We noted that regular staff supervision sessions were held and an annual appraisal was undertaken. Supervision and appraisals are used to review staff performance and identify any training or support requirements. 'Themed' supervision sessions were also held. The manager said, "We do themed supervision every month where we discuss feedback from the residents' steering committee, relatives' meetings, team meetings or any policy or procedural changes when a message needs to be got across to the whole body of staff. We also supplement these with one to ones and my door is always open." One staff member told us that they did not appreciate these themed supervision sessions. They said, "We are just given these forms and told to go away and read them and there is not enough space to write what you think. We spoke with manager about this feedback. She told us that she had amended the form and discussed the process with staff. She said, "They are never meant to be 'go away and read this' sessions. They are a two way process to make sure that staff understand. I have discussed this with the seniors."

Clinical supervision was also carried out. Clinical supervision is a formal process of professional support and learning which enables nurses to develop their knowledge and competence. One of the nursing staff told us, "We do clinical supervisions and have reflective discussions where we get together and discuss practice. We did a review of how things went with the care of a resident who had [name of condition] and discussed subsequent things that show where we can change our practice in the future. We do reflective accounts and we all find it useful." This meant that opportunities were available for nursing staff to be able to demonstrate that they had the professional standards and competencies needed to continue to practise as a nurse.

We noted that people were supported to access healthcare services. We read that people attended appointments with their GP, consultants, dietitian, speech and language therapist, dentists, opticians and podiatrists. One relative said, "They get first class healthcare." This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met to maintain their health.

Staff used the "Situation, Background, Assessment and Recommendation" (SBAR) to communicate with health care professionals such as GPs. The SBAR technique provides a framework for communication between members of the health care team about an individual's condition. This process meant that health professionals were fully aware of all the relevant information before visiting or providing advice.

We saw that careful consideration had been given during the refurbishment stage to ensure that the design and décor of the environment met the needs of those who had a dementia related condition. Corridors had specific themes such as the Royal family, Northumbrian farming, horse racing and a holiday corridor. A staff member told us, "The environment is so much better, the pictures and decoration is so good. It's a great starter for conversations." We saw there was a laundry area where old fashioned underwear was pegged onto a washing line along one of the corridors. The manager said, "It's a really good talking point. Even [name of person] who doesn't use any words will pass it and have a giggle." One of the lounges had been turned into "Grandma's sitting room." This was filled with historical artefacts which people could pick up and examine. The dining room in the dementia unit led out onto a secure patio area which had raised flower beds and seating. One person was sunbathing and waved to us.

There were kitchen areas in each of the dining rooms where people could make their own drinks and prepare snacks. There was also a hairdresser room which had an old fashioned dryer and nostalgic pictures of bygone days were displayed. The challenging behaviour clinician told us, "They [people] much prefer the set up downstairs. They have far more freedom."

Good

Is the service caring?

Our findings

People and relatives were complimentary about the caring nature of staff. Comments from people included, "The staff are very obliging and good especially the night staff," "The staff are nice." Relatives told us, "Everyone is treated equally with the same kindness and humour…They care for him as an individual, they know his likes and dislikes," "They spend time with them, putting hand cream on their hands and giving them hand massages," "Their dedication is incredible. I come in at all times and I have never seen one member of staff that wasn't patient," "What I like is that they will sit with people when they are poorly…I like the way they interact and talk with them, they are so kind. I think they go the extra mile" and "The staff are thoughtful, they know [name of person] loves football and if they are at home, they will phone him up and say 'Are you watching the football?' It's just little things like that which make a difference."

Health and social care professionals were also complimentary about the staff. The challenging behaviour clinician told us, "They have delivered some really good care." The nurse assessor said, "They know their residents well and everyone always looks presentable."

Staff spoke enthusiastically about ensuring that people's needs were at the forefront of everything that they did. One staff member said, "It's all about the residents. They are why we are here." The manager told us, "Everyone keeps the residents to the core and central to what they do."

We spent time visiting people in their rooms and talking with people in communal areas. Some people were cared for in bed due to their condition. We saw that they appeared comfortable and looked well-presented.

We spent time on both the dementia and nursing units. We saw positive interactions between staff and people throughout our visits to the service. We observed one person looking after a doll which appeared to give her comfort. A staff member told us, "Dolls are really good therapy, they have a calming effect. There's always a calmness around babies and this is imparted to people and it gives them a purpose while they are sitting there, cuddling the doll."

Staff displayed warmth when interacting with people whose behaviour could be described as challenging. Staff were very tactile in a well-controlled and non-threatening manner. Some people reached out for a hug which was immediately given.

We saw that staff were respectful in their approach. They treated people with dignity and courtesy. Staff spoke with people in a professional and friendly manner, calling people by their preferred names. We found that people's privacy was promoted by staff. We saw they knocked on people's bedroom doors before they entered. We observed care staff assisted people when required and care interventions were discreet when they needed to be. One person told us, "I've had two mishaps since I've been here and staff were really good and helped me."

We found the care planning process centred on individuals and their views and preferences. Care plans contained information about people's life histories which had been developed with people and their

relatives. One person's care plan stated that they liked music and "a hug always makes me smile." Another person's care plan explained how they liked sport and had previously played football for their local village club.

The manager told us and records confirmed that they had started to complete one page profiles for people which gave an overview of people's needs. One member of staff said, "We have started doing one page profiles which helps us get to know the residents even better. It's all about person centeredness. Like, one resident used to be a night shift worker and she likes to walk the corridors and check everyone. We know why she is doing this and don't stop her. We like to find out their background to give us insight into their ways." Another staff member told us that one person had been in the Royal Airforce and liked a "no nonsense" approach to their care. This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life.

People and relatives told us that they were involved in their care and support. We saw that people had signed their care plans where they were able to indicate that they agreed with what was planned.

Good

Is the service responsive?

Our findings

People and relatives informed us that staff were responsive to people's needs. Comments included, "I am happy with everything, there are no improvements I can think of," "The staff are responsive, they always come when you need them, sometimes not immediately," "The staff are always prepared to go that extra mile" and "I see lots of evidence of staff tending to each resident's individual needs."

The clinician for challenging behaviour told us, "I have no concerns with the care. They have done some really good work [around one person's behaviour]. There was a blip with recording but this was resolved."

Each person had a care plan for their individual daily needs such as mobility, personal hygiene, nutrition and health needs. These gave staff specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions.

We checked how people's social needs were met. An activities coordinator was in post. She spoke enthusiastically about ensuring that people's social needs were met. She told us, "We try anything. We do arts and crafts, painting, bingo, bowls which they love, quizzes and trips out. Some of the residents are on a 12 week course at Alnwick gardens. It's for people with dementia and they do things like baking, silk painting, there was a bee's talk, rookie golf and a garden tour. At the end of the course they get to keep everything they have done. I also have the church people coming in once a month. The majority of people love music. Music communicates across everyone."

People and relatives were complimentary about the activities and said that activities provision had improved. One relative said, "It's not just films, they get the residents out and involved and they have a trolley which goes around that residents can buy things from, there's a lot more on it now, like toiletries." We saw people involved in activities throughout our inspection visits. People accessed the local community, enjoyed sunbathing, participated in quizzes and games and some visited a local historical garden. This meant that people's social needs were met in line with their preferences.

There was a complaints procedure in place. The manager documented all concerns and "grumbles." The manager had written a letter to apologise to two people who used the service following their complaint about the absence of Yorkshire puddings and the toughness of the roast beef.

There was a steering committee which comprised of people who lived at the home. We read the minutes of the most recent meeting which was held on 20 July 2016. The manager had discussed the menus, the anonymous concern that CQC had received and the outcome of the local authority's visit. The manager told us that she was going to seek the support of an advocacy service to help ensure that the views of all were obtained including those who had a dementia related condition.

'Residents and relatives' meetings' were also held to obtain feedback from people and relatives. We attended a meeting which was held on Saturday 24 July 2016. Eight relatives and one person who lived at the home attended. The manager started the meeting by stating, "It would be fabulous if anyone wanted to

chair the meeting, it would then be your agenda and your meeting." The manager told those attending the meeting that they were working on an intergenerational project with the local high school. She said that the pupils were going to visit the home on a regular basis. She said, "We really want to develop this relationship…people with memory loss really love to see children." Activities, staffing levels, feedback from the local authority's quality monitoring visit, menus and the new management company were discussed. The manager explained that there was a new complaints procedure in place since the new management company had taken over.

Requires Improvement

Is the service well-led?

Our findings

We identified several shortfalls during our inspection. These related to the premises, meeting people's nutritional needs, the assessment of staffing levels and evidencing that the provider was following their responsibilities under the MCA. Although audits had highlighted some of these issues such as concerns regarding the fire alarm and nurse call systems, action was not always taken in a timely action to address these.

There was a manager in place who had commenced employment at the service in September 2015 and became registered with the Commission in May 2016. Most people, relatives and staff spoke positively about her. Comments from people and relatives included, "[Name of manager] is a great advertisement for the home. She listens to what we say," "Since the manager started she has made such inroads. She has been excellent," "The manager is lovely," "She has a great sense of humour" and "She steers the ship well. She knows exactly where she is going." Comments from staff included, "Our manager is quirky. She has a different approach to other managers and has more contact with the residents" and "The manager has grown on me, I find her approachable and she gets things done." Several staff and a relative told us that they did not like her management style. We spoke with the manager about this feedback. She told us that the most important part of her job was "the residents" and ensuring their needs were met and then making sure that the staff were happy. She told us that her door was always open for people, relatives and staff to come and talk to her about any issues or concerns.

We received positive feedback from health and social care professionals about the manager. Comments included, "I find the manager very welcoming and accommodating" and "She is very passionate about what she does."

The manager told us that she had completed her nurse training and previously worked as a nurse. She explained and our checks confirmed that she had chosen not to renew her registration with the Nursing and Midwifery Council. This meant she could not practice as a nurse. There was currently no clinical lead in place to oversee the clinical aspects of the service because the previous deputy manager/clinical lead had stood down from their role. One of the staff told us, "We haven't had a deputy manager for a good few months and I think we are missing this." We spoke with the manager about this feedback. She told us that they were actively trying to recruit for this post.

Staff spoke positively about the dementia care unit manager. "[Name] has been incredible, she has guided me through" Some staff felt that she had taken on extra management duties which had taken her away from the care which she was so good at. We spoke with the manager about this feedback. She told us, "[Name of unit manager] has been focussing on the rewriting of the care plans. It's been positive because it's enabled her to write, review and evaluate people's care."

There had been several changes in the provider's management structure over the past two years. A new company called Careport had taken over the operational management of the service on 11 July 2016. Careport manages care homes across the UK on behalf of their owners. The manager and staff spoke

positively about this change. The new regional manager of the home had previously been the registered manager of Hillcrest Care Home and knew the service very well. She told us, "The residents are absolutely at the heart of the home. You can't help but smile when you see how staff interact with the residents, it's lovely…The caringness [of staff] just knocks you over."

Most staff told us that morale was good and they enjoyed working at the service. Comments included, "Morale is good," "It's a lot better, everything is going well" and "We work well as a team. There' no animosity, no egos and no bad atmosphere." Staff said morale had dipped because of the disruption caused by the building works and confirmed morale had improved following the completion of the refurbishment.

Audits and checks were carried out on all aspects of the service including care plans, the dining experience, health and safety, accidents and incidents and medicines. One of the nursing staff told us, "We have asked to see the [medicines] audits and see what was identified. We are getting better now at not overstocking." We spoke with the pharmacy technician who said, "They have fantastic audit tools but they need to remember to fill in the action plans [on the medicines audits]." We spoke with the manager about this feedback, she told us that this would be addressed and medicines action plans would be completed.

Systems were in place to monitor people's finances. Manual records were kept to record and monitor financial transactions and purchases. A computerised system was also in place to record people's finances. Manual records relating to people's finances were up to date and accurate. We noted however, that the computerised system had not been recently updated to reflect any recent transactions and purchases. The manager told us that this would be addressed.

People participated in the running of the service. 'Residents' steering committee meetings' were held to consult on the views of people who lived at the home. People were involved in staff recruitment. The manager told us, "Previously we would go home and the residents would be left with staff which we had recruited - they hadn't been involved. Now they are cared for by staff who they have chosen. They decide whether staff are offered a job." This was confirmed by one of the people we spoke with. People were also involved in carrying out audits. The manager told us, "[Name of person] did the infection control audit with me. She thought it was hysterical having to wear blue gloves, aprons and hats when we went into the kitchen." We met one person who had opened the home following the service's recent refurbishment. She proudly showed us a photograph of herself and the mayor.

The manager told us that surveys were carried out to obtain the views of people and relatives. She said that they had not received the results from the 2015 survey from the provider. This meant we were unable to review feedback from people and relatives which had been obtained the previous year.

Staff meetings were carried out. Most staff told us that they could raise any issues and felt their views would be taken into account. Several staff told us that their views were not taken into account. Weekly 'heads of department' meetings were held. Housekeeping staff, nurses, senior care workers, maintenance and the manager attended these meetings to discuss all aspects of the service. We attended a meeting on 25 July 2016. Accidents and incidents, tissue viability, equipment, activities, housekeeping, medicines, staffing, feedback from the residents' steering committee and the premises were discussed. The manager told us, "I always start with accidents and incidents and any safeguarding issues because these are the first indicators that all is not well in a service."

Handovers were held at the beginning of each shift. This procedure helped staff provide continuous and safe care. We attended a handover meeting on the nursing unit. Staff discussed each person's current condition, any healthcare needs and appointments, and any changes in their medicines. We heard that one person

had received subcutaneous fluids overnight; another individual had required analgesia for pain and a GP had reviewed a third person's medicines. Specific instructions were also given during the handover, "[Name of person] is requiring care every two hours please," "Can you follow up on [name of medicine] for [name of person]" and "Can you make sure the ambulance is booked for [name of person]."

The manager attended the local nursing homes managers' meetings which were facilitated by the community matron for nursing homes. These meetings took place to share good practice and experiences of nursing homes in the area. The community matron for nursing homes confirmed that the manager attended these meetings and Hillcrest Care Home had also hosted several of these meetings.

We were contacted by a manager of a nearby nursing home. He had visited Hillcrest Care Home to look at the dementia care environment and gain ideas for their own service. He stated, "I sought advice from [name of manager] in making plans to improve our premises to be more dementia friendly. She invited me and my team to her home and we learned much about how she strategised her decorations and implemented changes. She went out of her way to answer all the questions we had and I will never be able to repay back the valuable knowledge and skills I gained from her experience. At no time did I feel patronised nor inadequate. Her willingness to share knowledge and her camaraderie attitude just shows that, as Nursing Homes, we are stronger together in unity rather than in competition. She goes further by sharing information on current compliances and how we can do well for the benefit of people in our care. That shows a deep understanding of multi-disciplinary working and integrity… In short, [name of manager] is caring, professional, knowledgeable, intelligent and keen to provide the best care possible."

Since April 2015, adult social care providers have to comply with the Duty of Candour regulation. This regulation states that providers must be open and transparent with people and those acting lawfully on their behalf about their care and treatment, including when it goes wrong. We found that the manager and the new management company were very open and transparent throughout the inspection process. We saw evidence that the manager had written to one person about a complaint they had made and offered an apology.

The manager had submitted notifications to CQC in keeping with their obligations under the Care Quality Commission (Registration) Regulations 2009. The previous CQC inspection ratings were clearly displayed at the service in line with the regulations.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always provided with a suitable and nutritious diet. Regulation 14 (1)(2)(4)(a)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Some of the front covers on the radiators were broken and hanging off which was a health and safety risk. Regulation 15 (1)(e).