# Abbeyfield Society (The)

# Hill House

## Inspection report

Combe Raleigh
Honiton
Exeter
EX14 4UQ

Tel: 0140446694

Date of inspection visit:
17 July 2018
26 July 2018

Date of publication:
05 September 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This unannounced comprehensive inspection took place on 17 and 26 July 2018.

Hill House 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 accommodates 30 people in one adapted building. At the time of our inspection there were 30 people living at the service.

Following the last inspection in August 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Safe, Effective, Responsive and Well-led to at least good. At the previous inspection, we found the provider had failed to ensure staff received appropriate support, training and supervision. The provider also did not operate effective systems to ensure improvements were made to the quality and safety of the service. Records were not always accurate, complete and contemporaneous in respect of each service user. This inspection found improvements had been made. Staff were now receiving up to date training and support and systems to monitor the quality and safety of the service were more robust.

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 2008 and associated Regulations about how the service is run.

Staffing levels met people's personal care needs. However, meaningful interactions were limited. The service was actively trying to recruit more staff to increase staffing levels. The service provided safe care to people. One person commented: "It's the staff, they make me feel safe". Measures to manage risk were as least restrictive as possible to protect people's freedom. People's rights were protected because the service followed the appropriate legal processes. Medicines were safely managed on people's behalf.

Care files were personalised to reflect people's personal preferences. Their views and suggestions were taken into account to improve the service. People were supported to maintain a balanced diet. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were caring and supportive. Staff were motivated to offer care that was kind and compassionate.

There were effective staff recruitment and selection processes in place. People received effective care and support from staff who were well trained and competent.

Staff spoke positively about communication and how the registered manager worked well with them.

A number of more robust methods were used to assess the quality and safety of the service people received. The service made continuous improvements in response to their findings.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staffing levels met people's personal care needs. However, meaningful interactions were limited. The service was actively trying to recruit more staff to increase staffing levels.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

People's risks were managed well to ensure their safety.

There were effective recruitment and selection processes in place.

Medicines were safely managed on people's behalf.

Staff ensured infection control procedures were in place.

### Is the service effective?

Good

The service was effective.

Staff were now receiving training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well.

People's rights were protected because the service followed the appropriate guidance in terms of the Mental Capacity Act (2005).

People were supported to maintain a balanced diet.

### Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

Staff relationships with people were caring and supportive. Staff

spoke confidently about people's specific needs and how they liked to be supported.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

## Is the service responsive?

Good

The service was responsive.

Care files were personalised to reflect people's personal preferences.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

## Is the service well-led?

Good

The service was well-led.

A number of more robust methods were used to assess the quality and safety of the service people received.

Staff spoke positively about communication and how the registered manager worked well with them.

People's views and suggestions were taken into account to improve the service.

The organisation's visions and values centred around the people they supported. The values had been embedded in staff practice.

# Hill House

**Detailed findings**

## Background to this inspection

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

This unannounced comprehensive inspection took place on 17 and 26 July 2018.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses older people care services.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke with 14 people receiving a service; three relatives and 12 members of staff, which included the registered manager. We spent time talking with people and observing the interactions between them and staff.

Some people living at the service were unable to communicate their experience of living at the home in detail with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We reviewed three people's care files, three staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. After our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. Unfortunately, we did not receive any feedback.

Good

# Is the service safe?

## Our findings

Staffing levels met people's personal care needs. Staffing arrangements were five staff in the morning, four in the afternoon supported by a senior care worker and three care workers at night. Care staff were supported by a cook, kitchen assistant, a laundry person, cleaners, activity coordinators, gardener and a maintenance person. The registered manager was also available and was supernumerary. All staff felt that although people's personal care needs were met, there was limited time for meaningful interactions. For example, time to chat about things which interested people. We observed staff providing people with personal care in a timely way. At lunchtimes, staff were visibly available in the dining room to assist people and were ensuring time to talk to people about the food and whether they needed anything else.

We discussed this with the registered manager. They had already recognised through assessing people's needs that staffing levels needed to be increased and were actively trying to recruit more staff. They planned to have an additional member of staff on both the morning and afternoon shifts. In the interim, some shifts were covered by consistent agency staff. Some shifts had already been increased to the preferred number, which was six in the morning and five in the afternoon.

We received mixed views about staffing levels from people living at the home. People commented" "I think there are enough staff"; "Staff often pop their head round the door and says hello"; "Sometimes there's a long wait for someone to come to me"; "Bell is a bit hit and miss on how long they come"; "There's a wait for the bell - depends who is around"; "Very helpful if I need anything" and "They are so busy but always willing to help me." The registered manager monitored call bell response times as part of their audit system. Where issues were identified they had taken action. For example, a recent survey had been undertaken to find out what times people preferred to get up and go to bed. This had enabled staff to assist people had their preferred time. For example, some people liked to get up early and therefore, night staff supported these people.

The service provided safe care to people. People commented: "It's the staff, they make me feel safe"; "I feel very safe living here"; "I feel safe with my button on (call bell pendant)" and "I do feel safe when they (staff) help me with care." A relative commented: "I have no concerns about (relatives) safety." Staff responded appropriately to people's needs and interacted respectfully to ensure their human rights were upheld. For example, staff communicated with people in a way they understood in order to meet their needs.

To minimise the risk of abuse to people, all staff undertook training in how to recognise and report abuse. Staff told us they would immediately report any concerns to the registered manager and were confident that action would be taken to protect people. A staff member commented: "I would go straight to (registered manager) and report. I would also document all the details."

People's individual risks were identified and risk assessment reviews were carried out in a timely way to keep people safe. For example, risk assessments for falls, moving and handling, skin care and nutrition. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, encouraging people to remain as independent as

possible with the use of moving and handling equipment.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, care plans and risk assessments updated. Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, where needed involvement of other health and social care professionals was requested to review people's plans of care and treatment. This demonstrated that the service was both responsive and proactive in dealing with incidents which affected people.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks, which included references from previous employers and Disclosure and Barring Service (DBS) checks, were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

At our inspection in August 2017 we found medicines were stored securely but not always at the temperature recommended by the manufacturer. At this time, records showed on several days in April 2017 the temperature of the room which stored medicines was over 25 degrees centigrade. The registered manager had been aware of this and concerns had been raised with the provider. The registered manager explained that an air conditioning unit was to be fitted to the room to reduce the temperature, although no date for this had been confirmed. At this inspection we found the air conditioning unit had been installed and the temperature of the room was consistently below 25 degrees centigrade. People received their medicines safely from staff who had received training to carry out this task. Medication administration records were correctly signed when they were administered. Certain additional checks had been put in place by the home to ensure that people received the correct type and dose of medicines. For example, audits were carried out on a regular basis.

Staff ensured infection control procedures were in place. Personal protective equipment was readily available to staff when assisting people with personal care. For example, gloves and aprons. Staff had also completed infection control training.

The premises were adequately maintained through a maintenance programme. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. People had personal emergency evacuation plans (PEEPs), which are individual plans, detailing how people will be alerted to danger in an emergency, and how they will then be supported to reach safety. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

Good

# Is the service effective?

## Our findings

At our last inspection in August 2017, we found staff had the knowledge they needed in order to carry out their roles and understood people's needs. However, several aspects of staff training had lapsed and some training was out of date, with staff requiring refresher training. Staff received annual appraisals however supervision of staff had lapsed. This inspection found improvements had been made.

Staff had completed an induction when they started work at the service, which included training. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction formed part of a probationary period, so the organisation could assess staff competency and suitability to work for the service. Also, to check whether new staff were suitable to work with people.

Staff received training, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. People commented: "They (staff) all know what they are doing"; "The staff seem to know what they are doing" and "They (staff) appear competent and well trained." Staff commented: "We are chased about training we need to update" and "I received relevant training when I started here."

Staff received training on a range of subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), moving and handling, first aid, equality and diversity. Also on a range of topics specific to people's individual needs. For example, dementia awareness. Staff had also completed nationally recognised qualifications in health and social care, including the care certificate. The care certificate aims to equip health and social care staff with the knowledge and skills which they need to provide safe, compassionate care.

Staff received on-going supervision and appraisals in order for them to feel supported in their roles and to identify any future professional development opportunities. Staff confirmed that they felt supported by the registered manager. Staff commented: "The support has been really good" and "I have been supported through lots of things." This showed that the organisation recognised the importance of staff receiving regular support to carry out their roles safely.

Staff knew how to respond to people's specific health and social care needs. For example, recognising changes in a person's physical health. Staff spoke confidently about the care they delivered and understood how they contributed to people's health and well-being. For example, how people preferred to be supported with personal care. Staff said they felt that people's care plans and risk assessments were useful in helping them to provide appropriate care and support on a consistent basis. One commented: "I always refer to the care plans if I am unsure of anything."

People were supported to see appropriate health and social care professionals when they needed to meet their healthcare needs. We saw evidence of health and social care professionals' involvement in people's

individual care on an on-going and timely basis. For example, GP and community nurse. These records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. For example, timely contact with the community nursing team to assess a person's pressure areas.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's legal rights were protected because staff knew how to support people if they did not have the mental capacity to make decisions for themselves. People's capacity to make decisions about their care and support were assessed on an on-going basis in line with the MCA. People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, for suitability of placement and advance decisions regards to end of life care. This demonstrated that staff worked in accordance with the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person had a DoLS in place and the registered manager had submitted a further 12 applications to the local authority DoLS team which were pending assessment.

People were supported to maintain a nutritious and balanced diet. People were involved in choosing what they wanted to eat to meet their individual preferences. A clear pictorial menu plan was on view just outside the dining room. This displayed the 'days' choices whilst the tables had a more detailed menu.

People commented: "I'm not good at chewing so I like the soup but staff will mash my food for me"; "There's plenty of food"; "Not enough - but it's lovely"; "No complaints" (would tell my son if not happy)"; "Can have something else if I want"; "It's always hot and tasty"; "They mince mum's food - not very appetizing but she has problems swallowing."

Meals were cooked freshly on the premises and were warming and nutritious. For example, on the first day of our inspection, people were enjoying roast ham, cauliflower cheese and potatoes with a dessert choice and the second day people had sausage and mash. Alternatives were also available, such as salads, soup and sandwiches. The mealtime experience was a social occasion for people. The home smelt lovely with the smell of home cooking.

Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. People's weights were monitored on a regular basis. Staff recognised changes in people's nutrition with the need to consult with health professionals involved in people's care. Speech and language therapists worked closely with people with speech, language and communication problems, and with those with swallowing, drinking or eating difficulties. As a result, people were prescribed specific diets to reduce the risks and staff followed the guidance.

People's individual needs were met by the adaptation, design and decoration of the premises. The home was set over three floors and was accessible by a lift. People had a variety of spaces in which they could spend their time, such as the lounge and dining room and their bedrooms were personalised. Reasonable adjustments had been made to enable people to move around as independently as possible, such as grab rails and ramps.

Good

# Is the service caring?

## Our findings

Hill House continued to provide a caring service to people and was very much people's home. People had built strong relationships with staff. There was a happy atmosphere. People commented: "Staff are caring, kind and patient. They understand (relative) needs"; "The staff are very caring"; "They (staff) look after me well"; "Very pleased with mum's care"; "Mum's really happy - I've come to take her for a picnic outside" and "Mum is very happy here - I have no complaints."

Throughout the inspection there were kind and friendly interactions between people and staff. Staff knew people well and were able to communicate effectively with everyone. Staff took time for people to communicate their wishes through the use of individual cues. For example, looking for a person's facial expressions, body language and spoken word.

Staff showed patience and supported people in a way that promoted their dignity. For example, a person needed support with personal care and a member of staff quietly took them to a bathroom where they could assist them in private. People had unrestricted access to their bedrooms and were able to spend time alone if they chose to. Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example, by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. A person commented: "They (staff) always ensure my privacy and dignity."

Staff adopted a positive approach in the way they involved people and respected their independence. For example, encouraging people to do as much as possible in relation to their personal care. A person commented: "I am encouraged to stay as independent as possible." Staff recognised how important it was for people to be in control of their lives to aid their well-being. For example, offering people choices of how they spent their time.

Staff gave information to people, such as when activities were due to take place and when lunch was ready. Staff communicated with people in a respectful way. Their relationships with people were caring and supportive and they spoke confidently about people's specific needs and how they liked to be supported. Staff offered care that was kind and compassionate. For example, we saw staff working closely with people, engaging with them in a way they responded positively to. Staff were interacting with people in a kind and gentle way throughout our inspection. Staff explained it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything. One person commented: "I know I have a care plan."

The service had received several compliments about the care provided to people. For example, 'To all the staff at Hill House, many thanks to you all for the tender care given to our mother, during the last year. She told us often how kind everyone was and how well you looked after her' and 'Many thanks to you all for the care and devotion shown to our mother since her arrival.'

Good

# Is the service responsive?

## Our findings

Staff knew people very well and provided care and support which was person centred and took account of their needs and wishes.
Care files included personal information and identified the relevant people involved in people's care, such as their GP. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate.

Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care. Staff commented that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Care plans were up-to-date and were clearly laid out. They were broken down into separate sections, making it easier to find relevant information, for example, physical and mental health, nutrition, continence, skin care, mobility and personal care. Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care records contained communication details explaining how people communicated and the need to speak clearly to ensure they could communicate their wishes. For example, due to hearing difficulties.

Activities formed an important part of people's lives. The service employed two activities coordinators which enabled people to engage in a variety of activities and spend time in the local community. For example, discussion groups, outside entertainers, arts and crafts and visits to places of specific interest. One person commented: "Loved painting the stones." One of the activities coordinators spoke about piano and hand massage sessions which took place when both coordinators were working and how this was an activity very much enjoyed by people. Other examples were trips to garden centres and to the donkey sanctuary.

People were encouraged to maintain relationships with their friends and family. For example, care plans documented the importance to people of seeing their family and friends. The registered manager was also in the process of trying to install WIFI to enable people to communicate with their families through the use of technology. This was taking some time due to the poor internet connection in the area.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments. This was through on-going discussions with them by staff and members of the management team. People were made aware of the complaints system when they started using the service. They said they would have no hesitation in making a complaint if it was necessary. People commented: "My son helps

if I have any problems" and "I have no complaints, but could raise if I needed." The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. Where a complaint had been made, there was evidence of it being dealt with in line with the complaints procedure.

People were supported at the end of their life. However, at the time of the inspection there was no-one receiving this type of service. The registered manager said, in the event of this type of support, they worked closely with the community nursing team; GP's and family to ensure people's needs and wishes were met in a timely way.

Good

# Is the service well-led?

## Our findings

At our last inspection in August 2017, we found the provider did not operate effective systems to ensure improvements were made to the quality and safety of the service, including the quality of the experience of service users in receiving those services. Records were not always accurate, complete and contemporaneous in respect of each person. This inspection found improvements had been made as cited in this report.

More robust audits had been implemented following guidance from the Quality Assurance Improvement Team (QAIT). The QAIT team offers advice and support providers to meet the quality standards and requirements of regulators and local authority. Audits reviewed people's care plans and risk assessments, incidents and accidents and health and safety. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up.

For example, maintenance jobs completed and additional staff training arranged. Provider quality monitoring visits had also taken place to ensure oversight of the service. The last one was carried out on 12 July 2018. Where actions were needed these were being followed up by the registered manager. For example, recruitment of a deputy manager to help with the overall running of the service. This showed the service was committed to continuous improvement.

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 2008 and associated Regulations about how the service is run.

Staff spoke positively about communication and how the registered manager well with them and encouraged an open culture. Staff felt able to raise concerns and were listened to. Staff meetings occurred on a regular basis. Staff confirmed they were kept up to date with things affecting the overall service via team meetings and conversations. Additional meetings took place as part of the service's handover system which occurred at each shift change. However, care staff felt senior carers were not team players on occasions, spending a lot of their time in the office and raised concerns about their attitudes at times. They added that the issues had become more apparent since the deputy manager left. This was because senior carers were now having to do additional tasks which had been delegated to the deputy manager.

We discussed this with the registered manager. They had already recognised this as a problem and had tried to address these in a staff meeting in June 2018. The registered manager is now arranging a senior's staff meeting to address the issues. In addition, the service was actively trying to appoint a new deputy manager.

People's views and suggestions were considered to improve the service. Resident meetings took place, with the last being on 11 July 2018. This meeting took into account people's views about the food, activities and

any other issues. Surveys had also been completed by people using the service. The surveys asked specific questions about the standard of the service and the support it gave people. Where actions were required these had been followed up by the registered manager. For example, an activities survey was used to find out what people enjoyed doing and a food survey for people's preferred meal choices. This showed that the organisation recognised the importance of continually improving the service to meet people's individual needs.

People's equality, diversity and human rights were respected. The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. Our inspection found that the organisation's philosophy was embedded in Hill House.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP and community nurse. Medical reviews took place to ensure people's current and changing needs were being met.

The registered manager had notified CQC appropriately. We use this information to monitor the service and ensure they respond appropriately to keep people safe. The provider had displayed the rating of their previous inspection in the home, which is a legal requirement.