Mariposa Care Limited

Hillcrest Care Home

Inspection report

off South Road
Alnwick
Northumberland
NE66 2NZ

Tel: 01665604464
Website: www.executivecaregroup.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hillcrest is a 'care home.' People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation and care for up to 52 people, some of whom are living with dementia. Accommodation was divided into two units across two floors. Those who had a dementia related condition lived in accommodation on the ground floor and those with nursing needs lived on the first floor. There were 49 people living at the home at the time of the inspection.

This inspection took place on 2 October 2018 and was unannounced. This meant that the provider and staff did not know that we would be visiting. We carried out two further announced visits on 10 and 25 October 2018 to complete the inspection.

We last inspected the service in August 2017, where we found two breaches of the regulations. These related to meeting nutritional and hydration needs and good governance. We rated the service as requires improvement.

Following our inspection, the provider sent us an action plan which stated what actions they were going to take to meet the regulations.

At this inspection, we found that the provider had taken action in relation to meeting nutritional and hydration needs and good governance.

There was a registered manager in post. She had become registered with CQC following our previous inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The service was going through a period of change. The registered manager told us that she was trying to ensure the smooth running of the service amidst the changes which were happening to make sure people experienced the best possible outcomes at Hillcrest Care Home.

Whilst staff carried out their duties in a calm unhurried manner in the dementia care unit; staff in the nursing unit appeared to be constantly busy, moving from task to task, leaving little time to communicate on a social level. Some staff told us that team work could be improved between the units and also between the different shifts. We have made a recommendation about staff deployment.

There were systems and procedures to help protect people from the risk of abuse. People and relatives told us people were safe. Medicines were managed safely.

There was a training programme in place. Staff said however, that most of the training was online. They explained that it was sometime difficult to get online and said that they did not find e-learning as interesting or engaging as face to face training. We have made a recommendation about this.

There was a supervision and appraisal system in place. Supervision and appraisals had not been carried out as regularly as planned because several nurses and a senior care worker who supported the registered manager undertake these with staff, had recently left. There was a plan in place to address this shortfall.

People were supported to eat and drink enough to maintain a balanced diet. Nutritional care plans were individualised and included information about where the person liked to have their meal together with their likes and dislikes. Special recommendations from health care professionals were also recorded.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed positive interactions between staff and people who lived at the service. Staff talked about caring for people like members of their family.

There was an activities programme in place. An activities coordinator was employed to meet people's social needs. The registered manager said they were reviewing the home's activities provision to ensure that activities were person centred and promoted people's maximum involvement.

There was a complaints procedure in place. Records were available to document what actions had been taken to resolve the complaints.

Audits and checks were carried out to monitor the quality and safety of the service. Action was taken if shortfalls were identified. An overarching action plan was in place which was linked to CQC's five key questions.

This is the fourth time the service has been rated requires improvement.

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 always safe.

We received mixed feedback about staffing levels. Staff in the nursing unit appeared to be constantly busy. We have made a recommendation about staff deployment.

Safe recruitment procedures were followed.

There were systems and procedures to help protect people from the risk of abuse. Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported to eat and drink enough to maintain a balanced diet.

There was a training programme in place. Most of the training was online which staff said was not as interesting or engaging as face to face training. Supervision and appraisals had not been carried out as regularly as planned. A plan was in place to address this.

Staff were following the principles of the Mental Capacity Act 2005. 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. Staff talked about caring for people like members of their family.

Staff promoted people's privacy and dignity. They talked to people respectfully.

The service supported people and relatives to be actively involved in people's care.

Is the service responsive?

Good

The service was responsive.

People had a care plan in place which aimed to meet their physical, social and emotional needs.

There was an activities programme in place. 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.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service was going through a period of change. The registered manager told us that she was trying to ensure the smooth running of the service amidst the changes which were happening to make sure people experienced the best possible outcomes at Hillcrest Care Home.

Audits and checks were carried out to monitor the quality and safety of the service. An overarching action plan was in place which was linked to CQC's five key questions.

Hillcrest 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 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.

The comprehensive inspection took place on 2 October 2018 and was unannounced. We carried out a further two announced visits on 10 and 25 October 2018 to complete the inspection. The inspection was carried out by an inspector, a specialist advisor in nutrition 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.

Prior to our inspection, we checked all the information we had received about the service including notifications the provider had sent us. Statutory notifications are reports the provider must send us about deaths and other incidents that occur within the service, which when submitted enable us to monitor any issues or areas of concern.

We contacted the local authority's safeguarding and contracts and commissioning teams. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used their feedback to inform the planning of the inspection.

We did not request a provider information return (PIR) prior to the inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with 10 people who lived at the home, four relatives and one visitor. We also consulted with a community matron for nursing homes and a community matron.

We spoke with the regional manager, the registered manager, a nurse, an agency nurse, two senior care workers, five care workers, the activities coordinator, a housekeeper, the maintenance man and the chef. We

also spoke with one agency nurse and three care workers on night duty to find out how care was provided at night.

We examined six people's care plans and associated care records. We also checked records relating to staff and the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2017, we rated this key question as requires improvement. We identified a breach in the regulation relating to good governance. There were shortfalls with the management of medicines on the nursing floor.

At this inspection, we found that improvements had been made regarding medicines management.

We received mixed feedback from people and staff about whether enough staff were deployed. Comments included, "Yes I feel safe here. Lots of care staff around. I've got a buzzer to press if I need to" and "Yes there are enough staff. They are very good." However, others commented, "No there are not enough staff. Care workers haven't got time to do basic tasks" and "I don't see many staff. They give me my pills but I don't see them very often. The girls are good though."

The registered manager explained that staffing levels normally consisted of one nurse, a senior care worker and four or five care workers on the nursing unit and one senior care worker and three care workers on the dementia care unit. Two nurses had recently been recruited and consistent agency staff were used where there were any shortfalls in staffing. They were currently recruiting bank staff and a permanent care worker for night shift.

Whilst staff carried out their duties in a calm unhurried manner in the dementia care unit; staff in the nursing unit appeared to be constantly busy, moving from task to task, leaving little time to communicate on a social level. Staff explained that mornings between 8:30am and 10am were especially busy.

We observed that several people were left in their wheelchairs in the upstairs lounge rather than being assisted to sit in a comfortable chair. We asked a staff member about this issue and they explained that this was due to staffing levels.

The registered manager explained that they were always available to support staff as were the home's administrator and domestic staff who had completed the necessary training. They explained that staff needed to ensure they requested assistance if further support was required. It was unclear however, when the additional support was provided by non-care staff since this was not recorded on the staff rotas. Staff stated that the additional support provided was ad hoc and dependent upon which staff were on duty rather than being planned proactively.

We recommend that the provider reviews staffing levels to ensure and demonstrate that sufficient staff are deployed to proactively meet the needs of people.

Checks and tests had been carried out to ensure that the premises and equipment were safe. Some of the flooring on the nursing floor was uneven. The provider had been out and this was being addressed. Audits had highlighted that there had been inconsistencies in recording fire drills and instruction. This was being addressed and all fire drills and instruction were now being recorded.

The home was clean and there were no malodours apart from one person's room which we informed the registered manager about. Staff had access to and used personal protective equipment such as gloves and aprons.

A safe system was in place to receive, store, administer and dispose of medicines. People and relatives told us that medicines were generally administered as prescribed. Comments included, "I get me tablets in the morning and the evening. They are usually on time" and "Staff always bring tablets on time." One relative told us however, that there were sometimes delays in the administration of medicines which they had already raised with the registered manager. Medicines administration records were generally completed accurately. We noted that one person's medicine did not tally with the amount staff had recorded had been administered. The registered manager told us that she would look into this.

There were systems and procedures in place to help protect people from the risk of abuse. There were two ongoing safeguarding investigations. The registered manager was liaising with the local authority in relation to these incidents.

People and relatives told us people were safe. Comments included, "I feel very safe here. Very happy here" "I never worry about [relative], she is safe" and "I would say [relative] is safe here." There were safeguarding policies and procedures in place. Staff were knowledgeable about what action they would take if abuse was suspected. Staff did not raise any safeguarding concerns. Lessons learnt following safeguarding incidents were discussed with staff during meetings to help reduce the likelihood of any reoccurrence.

Safe recruitment procedures were followed to ensure that prospective staff were suitable to work with vulnerable people. Checks were carried out to ensure nurses were registered with the nursing and midwifery council.

Risks to people were assessed. Risk assessments had been completed for a range of areas such as moving and handling, falls, malnutrition and pressure ulcers. However, we visited a person in their room and noticed that one side of their bed rails had not been raised to help prevent them falling out of bed. We alerted staff to this issue and informed the registered manager.

Good

Is the service effective?

Our findings

At our last inspection in August 2017, we rated this key question as requires improvement. We identified a breach in the regulation related to meeting people's nutritional and hydration needs. People's meals did not always correspond with guidelines issued by the speech and language therapist. In addition, records did not always evidence how the Mental Capacity Act 2005 [MCA] was followed. At this inspection, we found that action had been taken and the provider had ensured good outcomes for people in this key question.

There was a system in place to ensure that staff had the skills, knowledge and experience to deliver care and support. People and relatives told us that permanent staff were well trained and knew what they were doing. One person told us, "Yes staff are good - well trained." A relative commented that agency staff were not as skilled as the permanent staff. The registered manager explained that they tried to ensure that the same agency staff were used for consistency. A community matron for nursing homes from the local NHS Trust provided clinical support and delivered training to staff.

We observed that staff were skilled at the duties they performed such as moving and handling. Staff stated that was training available. They said however, that most of the training was online. Some said they preferred a mixture of face to face and online training. Only nursing staff completed practical first aid training since the nurse on duty was the designated first aider. One staff member said, "A lot of the training is done online which is a bit boring, I think we should all be first aid trained [practical training]. I don't think you take enough in [when completing online training]." We noted that training statistics had fallen in certain areas which some staff attributed to being unable to get online to complete the training. The registered manager was aware of this issue and laptops were available at the home for staff to complete the necessary training.

We recommend that the provider reviews their training methods to make sure these meet the learning needs of staff to help ensure staff delivered safe and effective care.

There was a supervision and appraisal system in place. Most staff told us that they felt supported, several staff explained that more support would be appreciated. Supervision and appraisals had not been carried out as regularly as planned because several nurses and a senior care worker who supported the registered manager undertake these, had recently left. In addition, the clinical lead was not currently at work. There was a plan in place to address this shortfall.

People were supported to eat and drink enough to maintain a balanced diet. Most people and relatives were complimentary about the meals. Comments included, "Food is good. There's always plenty food on offer," "The food is lovely. The chef is very good but it hasn't always been good" and "Food has never been brilliant, but we have a new chef now…Sometimes he makes things that [relative] doesn't recognise. [Relative] likes food to be simple - mince and dumplings, that's what they like. [Relative] needs help to eat and generally they get it."

Nutritional care plans were individualised and included information about where the person liked to have

their meal together with their likes and dislikes. Special recommendations from health care professionals were also recorded. Menus for those people who required an altered textured diet such as a fork mashable or pureed diet followed the regular diet menu. Fortified foods and drinks were given to people throughout the day.

We observed the lunch time experience and saw that staff were attentive to people's needs. They provided discreet support when required and prompted and encouraged people with their meals.

The 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The registered manager had submitted DoLS applications in line with legal requirements. Mental capacity assessments had been completed for specific decisions such as any restrictions upon people's liberty. It was not always clear however; which individuals and professionals had been involved in these decisions. The registered manager told us that this would be addressed.

People were supported to access healthcare services and receive ongoing healthcare support. This was confirmed by people and relatives. Comments included, "An optician visits her regularly and a dentist does come here," "We have a doctor comes to the home if I'm not well" and "The GP comes to see me now. Someone is taking me to my own dentist tomorrow." We saw evidence in records that staff had worked with various agencies and accessed other services when people's needs had changed, for example, consultants, GP's, district nurses, speech and language therapist, dietitians, the chiropodist and dentist. The community matron for nursing homes, optician, community psychiatric nurse and GP all visited during our inspection. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were met to maintain their health.

People's individual needs were met by the adaptation, design and decoration of premises. People with a dementia related condition lived in accommodation situated on the ground floor. There was a reminiscence room which contained various artefacts and memorabilia to remind people of their past and encourage communication. One person picked up a pearl necklace and said, "Isn't this beautiful." Pictures and various items were displayed on the corridor walls which people could touch as they walked past. There were dining areas on both floors and lounges for people to relax.

Good

Is the service caring?

Our findings

At our last inspection in August 2017, we rated this key question as good. At this inspection, we found the provider had continued to provide good outcomes for people.

People and relatives were complimentary about the caring nature of staff. Comments included, "Yes, staff are very caring. They will do anything I want"; "Yes staff are caring when they have time, they will come and chat or give [relative] a hug, which they like. They sometimes talk to him about football as he's a big fan of football"; "I can't praise the staff enough, they always go the extra mile"; "They all hug me"; "I think they are angels"; "When I came in the other day, I saw one of the carers sitting holding someone's hand. They are good at looking after people who are poorly."

A number of written compliments had been received. Comments included, "Wonderful care"; "You dealt with [relative] with skill, gentleness and humour" and "She felt genuinely cared for."

We saw positive interactions between staff and people. Most of these were observed in the dementia care unit because staff were busier in the nursing unit and most people in this unit chose to stay in their rooms.

A staff member gave one person a hug and they both did a little dance together. Another person told a staff member, "I wouldn't want your job," the care worker smiled and took their hand and said, "Why not? It's the most rewarding job ever."

Staff talked about caring for people like members of their family. We asked staff if they would be happy for a friend or relative to live at the home. Comments included, "the care here is good, for the care yes – I would put a relative here, I think the care is exceptional"; "If she needed to be here, I would put my mum here"; "I love my patients"; "We call one person grandma – she loves that" and "I love it, we're like a family."

Staff promoted people's privacy and dignity. This was confirmed by people and relatives. One relative told us, "Staff don't shout across a room to her, they go over and speak to her quietly and personally." Another relative said, "Everyone I see are treated with respect and it is a huge thing."

The hairdresser attended the home on the last day of our inspection. She told us that an appointment system was now in place. She said, "We now have appointment times, so people aren't waiting, it's better for them and they have more special time and they're not waiting around."

People and relatives were involved in decisions about people's care. Six monthly care reviews were carried out. One relative told us, "I am involved though. I always get contacted if he falls. I am involved in the care plan reviews. I was also involved in the assessment for continuing health care." Another relative commented, "Staff have sat down and talked to [relative] and asked what she likes to eat, also her hobbies."

The registered manager told us that no one was currently accessing any form of advocacy and that she would look into advocacy services on an individual basis when the need for an advocate arose. Advocates

can represent the views and wishes for people who are not able express their wishes.

Good

Is the service responsive?

Our findings

At out last inspection in August 2017, we rated this key question as requires improvement. We found shortfalls in relation to people's records. At this inspection we found that improvements had been made and the provider had ensured good outcomes for people in this key question.

People had a care plan in place which aimed to meet their physical, social and emotional needs. Information relating to people's background and their likes and dislikes was included to help staff deliver more responsive care. Reviews were carried out and amendments made if there were any changes to people's needs.

Information relating to people's end of life wishes was included in care plans. Some people had an emergency health care plan in place which detailed important information in the case of a medical emergency. Information about whether a Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] decision had been agreed was also included in people's care files. The home had a syringe driver. A syringe driver is small pump which releases a dose of medicine at a constant rate. They are often used in the last few weeks and days of life but they can be useful for managing symptoms at any stage.

There was an activities coordinator employed. Most people and relatives said that there was enough going on to meet people's social needs. Comments included, "The activities coordinator is good - she takes people out sometimes. He really likes that," "[Relative] went upstairs for a sing-song yesterday and enjoyed it," "[Relative] doesn't join in much but if I come in and join in, he will do things" and "Sometimes I would like to do something that suits my age and ability, that would be good."

There was an activities programme in place. Activities such as arts and crafts, pamper sessions, table top games, floor games such as carpet bowls and bingo were carried out. More activities were beginning to take place outside of the home. People had recently been for lunch at a nearby pub. We spoke with a visitor who was a trained chair based exercise instructor. She was going to hold exercise sessions at the home.

During the inspection, various activities took place. There was bingo, quizzes and a sing a long session. A large cinema screen in the downstairs lounge was used to display words of songs, pictures and quiz questions. There was some enthusiastic singing and one person commented, "Oh, I've loved this session today. I love singing and dancing." Individual activities were organised. One person enjoyed doing jigsaws and others liked to paint. Staff affectionately named one person "Picasso" because their artwork was so good.

There were limited activities undertaken in the nursing unit. We discussed our observations with the registered manager. She told us that some people chose not to join in, whilst others enjoyed going downstairs and joining in with the activities in the dementia care unit. She said they were reviewing the home's activities provision to ensure that activities were person centred and promoted people's maximum involvement.

There was a complaints procedure in place. Records were available to document what actions had been taken to resolve the complaints. We spoke with one relative who had recently made a formal complaint. They told us that their complaint had been responded to appropriately and there had been no further concerns.

The registered manager was aware of the Accessible Information Standard to ensure the information and communication needs of people were met. The complaints procedure was available on an audio disc for those who were unable to read the written word. Care plans contained details of people's communication needs. Picture menus were in the process of being developed. The registered manager told us that they would contact head office if information was required in any other format.

Technology was used to help ensure people received timely care and support. Call bell systems were in place in people's rooms. Sensor alarms were also in place if people were at risk of falling.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2017, we rated this key question as requires improvement. We identified a breach in the regulation relating to good governance. There were shortfalls in the maintenance of records relating to people and the management of the service. At this inspection we found that improvements had been made regarding the management of records. However further action was required in relation to staff culture and the deployment of staff.

The manager had become registered with CQC since our last inspection. She had worked at the home for a number of years. She was not a registered nurse. A clinical lead was in post to oversee people's nursing needs. She was not at work at the time of the inspection.

People, relatives and most staff spoke positively about the registered manager. Comments included, "I know I can go to [registered manager] and she will always look into issues for me," "[Name of registered manager] should have a halo"; "[Name of registered manager] has been my teacher since I started. I have a lot of respect for her" "[Name of registered manager] knows everyone – she does well and her door is always open" and "The manager is lovely. She'll offer me a coffee if I want one. She gave me my pills yesterday. She always mucks in if needed." Several staff said that more support from the registered manager would be appreciated.

The service was going through a period of change. Two nurses and a senior care worker had recently left the service. Two nurses had been recruited and vacant shifts were being covered by consistent agency staff. The registered manager told us that she was trying to ensure the smooth running of the service amidst the changes which were happening to make sure people experienced the best possible outcomes at Hillcrest Care Home.

We spent time on both units during our inspection. Staff who worked in the dementia care unit told us they felt supported and enjoyed working at the home. Several staff on the nursing floor said that staffing numbers sometimes affected morale. They told us they considered team work could be improved between staff on both units and also between the different shifts. One staff member said, "There is a divide – it's like we're two separate homes." The registered manager was aware of this issue and was looking at ways of addressing the differences between the units and shifts to ensure that this did not impact upon people's care.

Audits and checks were carried out to monitor the quality and safety of the service. Action was taken if shortfalls were identified. An overarching action plan was in place which was linked to CQC's five key questions. Training and supervision had been highlighted as areas for improvement. This was being addressed at the time of our inspection. Staff spoke with us about the type of training available. They told us that more face to face and practical training would be appreciated. We spoke with the registered manager about this issue. She stated that she would raise this with the provider.

People and relatives were generally complimentary about the home. Comments included, "I have no

complaints about this place," "It's okay - maybe 6 out of 10. It's not the staff who work here but the number of staff who work here that would make the difference" and "Staff are really friendly. When I go home after a visit, I am confident with the care [relative] gets."

Systems were in place to encourage communication with people, their families, visitors and health and social care professionals. Since our last inspection, the registered manager's office had been relocated to the main entrance of the home. The registered manager explained that this had improved communication since she could speak with those coming into the home, provide any updates and answer any questions or queries. One relative said, "It's so much better having the office here." Another stated, "I would say it was well managed. The manager is always around and very approachable."

Surveys and meetings were carried out to obtain the views of people, relatives and staff. One relative said, "I do come to resident meetings and attend review meetings for care plans. I always get copies sent to me and we discuss all sorts of issues at resident meetings." The registered manager also held a 'Manager's surgery' where anyone could raise any issues or concerns. A "You said / We did" board was displayed in the entrance to the home. This listed the actions which had been taken following feedback from people and relatives. New dining rooms chairs had been purchased, the top garden had undergone a makeover and exercise classes had commenced.

The service sought to work with other agencies. They liaised with local health care providers including the local community hospital, the community matrons and GP's. They were accessing training from the hospice at home service. The registered manager explained they were looking to facilitate further links and increase their partnership working with different agencies and local community services.