Pressbeau Limited

Hill Top Lodge

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Hill Top Lodge was last inspected on 3 September 2013 where we found a shortfall in the number of staff so that people's needs were not always met. During this inspection we saw that although some actions had been taken there was still a shortfall in the number of staff. This inspection was unannounced which means that no one at the home knew we were going to inspect the home.

Hill Top Lodge provides nursing and personal care to up to 85 people. Accommodation is provided over three floors and there are adaptations in place to ensure that the needs of people with restricted mobility can be met. The home provides single bedrooms, lounges, dining rooms, bathing facilities and a small enclosed garden. At the time of our inspection there were 72 people living in the home.

Summary of findings

There was no registered manager in post at the time of our inspection but an acting manager had been appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We saw that people living in the home were not always protected from harm. Medicines were stored safely but arrangements were not fully in place to check that people were given their medicines as prescribed or on the days instructed by the prescriber. This meant that sometimes people had not received regular pain relief because pain relief patches had not been changed at the required intervals. Medicine administration records (MARs) were not always completed so that it was not clear that people had received their medicines or if not, why not. We saw that there was not always sufficient information for staff to give 'as and when required' medicines in a consistent and safe way.

We saw that people were not always protected from the risks of injury because safe moving and handling procedures were not followed. For example, we saw a wheelchair used without foot plates. This could result in injury to people's feet. Staff told us that foot plates should have been used.

We saw that equipment was not always adequately risk assessed and plans were not put in place to prevent people from being injured. For example there was a risk of scalding from hot water.

A new manager had been appointed but they had not been in post long enough to be registered with us. There were systems in place to monitor and improve the service; however, we saw that the systems in place had not ensured that people were safe. This meant that the provider was not meeting the requirements of the law in respect of medicines management, care and welfare of people, maintaining equipment and monitoring the quality of the service. You can see what actions we have asked the provider to take at the back of the report.

People told us and we saw that there were not always sufficient staff available to ensure that people's needs were met consistently. We saw that people had to wait to be assisted with their meals and for people to have social interactions so their emotional and social needs were met.

We saw that the manager was aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and applications for safeguards had been made for some people that required them but not all. It was not always clear that decisions made on behalf of people and actions taken in respect of their care were always in their best interests.

People or their relatives were involved in identifying people's needs so that staff had the information they needed to support them properly. Staff received training and supervision so that people were supported by staff that had the skills and knowledge to meet people's needs. We saw that people's dietary needs were met and people were supported to have their health needs met. However, we saw that people did not always know that they could ask for drinks throughout the day so did not always receive drinks when they wanted them.

People told us they were happy with the care they received and we saw that people were well cared for and individual differences respected and supported. People were supported to look well groomed and their privacy and dignity promoted. People were supported to maintain links with people who were important to them. This meant that people received support in a caring and compassionate way.

We saw that staff was caring and responded to people's distress in a kind and caring way but some people were not able to summon assistance quickly and safely because call bells were not accessible to them. There were activities to occupy some people but not sufficient to meet most people's needs especially people with dementia or those that spent most of their time in their bedrooms.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected from the risk of unnecessary harm from poor moving and handling procedures, inadequate safeguards in the administration of medicines and insufficient staffing at some parts of the day.

People were protected from abuse because staff had the skills and knowledge of the signs of abuse and the actions to take to protect people.

People's ability to make decisions was assessed but not everyone that needed protection through a DoLS application had been protected.

Inadequate

Is the service effective?
The service was not effective.

People or their relatives were involved in planning care so that people received care as they wanted. People had choices at mealtimes but they did not always get hot drinks when they wanted them because they did not know they could request them.

People were able to get medical help when they needed it.

Requires Improvement

Is the service caring?
The service was caring.

Staff responded to people in a kind and compassionate way and supported them to look nice and have privacy when needed.

People were able to have visitors when it was convenient for them and good relationships were developed with staff.

Good

Is the service responsive?
The service was not responsive.

Staff responded well to people's requests or expressions of distress

There was some support for people to have things to do that they found interesting and that kept them occupied but not everyone's needs were met.

People were able to raise concerns which were resolved and there was good involvement of other services in the home to ensure that people's needs were met.

Good

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

A new manager had recently been appointed and there were some systems in place to monitor the service.

Requires Improvement

Summary of findings

Systems had not ensured that people were protected from risks.

Improvements were needed to the ways in which views of people were gathered.

Hill Top Lodge

Detailed findings

Background to this inspection

This inspection was carried out by a team that consisted of two inspectors, one of who was a pharmacist 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 this type of care service. The inspection was carried out on 7 August 2014.

Before the inspection we reviewed the information we held about the service. This included notifications sent by the provider about deaths, accidents and safeguarding alerts. We also looked at reports received from other agencies such as the Local Authority safeguarding teams and the Clinical Commissioning Group. As part of our inspection process, we asked the provider to complete a Provider Information Return (PIR). This was information for them to tell us how they provided a safe, effective, caring, responsive and well led service. We received the PIR within the required timescale and used information from this to inform the inspection planning.

During the visit we spoke with 11 people that lived in the home, five staff members, two relatives, one friend, the acting manager and the provider's representative. We informally observed how the staff interacted with the people who used the service. We looked at six people's care records to see if their records were accurate and up to date. We looked at six staff recruitment files and records relating to the management of the service including quality audits, complaints, incident and accident records.

Inadequate

Is the service safe?

Our findings

The Medicine Management Care Home Team from Sandwell and West Birmingham Clinical Commissioning Group (CCG) had undertaken a visit to the service on 19 December 2013. Their report identified issues that required further action. In particular that audit procedures were not sufficient and had not detected concerns at an early stage. The supplying pharmacy visited the service on 3 June 2014 and identified that improvements had been made but some areas needed further action. During this inspection we saw that these improvements had not been made.

We saw that 11 of 33 medicine administration records (MAR) had gaps in them which indicated that people may not have received their medicines. One of the MAR charts had seven gaps on it. We were told that the person often refused their medicine however this reason had not been recorded. This meant it was not always possible to determine if people had received their prescribed medicines or the reason why they had not received them.

Appropriate arrangements were not always in place that ensured that medicines were given according to the prescriber's instructions. We found that medicines prescribed to be given on a particular day in the week for five people were not always given on the correct day. One person who had been prescribed a medicine as a skin patch for pain relief had not had their skin patch applied until the day after it was required. This meant that the person had not been given their pain relief as prescribed and may have suffered unnecessary pain as a result.

We looked at the records of eight people who were prescribed a medicine to be given 'when necessary' or 'as required' for agitation. We found that for three people no supporting information was available and four people had some available but it was not specific to the individual person. This meant that there was a potential risk that people may not have received their medicines in a safe and consistent way.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments were in place to protect people from risks such as the risk of injury from falls, skin damage and the use of bed rails. We saw some good examples of the safe and proper use of equipment but we also saw practices that could put people at risk of injury. For example, during our inspection we saw one person on the floor in their bedroom. Staff told us that the person had slipped onto the floor whilst they were being assisted with a hoist. Later in the day the person was moved to the lounge in a wheelchair without the use of footrests. Staff confirmed that foot rests should have been used. Some staff told us that there was a shortage of foot rests. This showed that although risk assessments were in place people were not always protected from the risks of injury due to the improper use of equipment. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person told us, "The first weeks it was wonderful but not now. No time to talk to you." One staff member told us, "It's okay at night but now it's a bit rushed (in the morning)." Another member of staff on a different floor told us that staff were over stretched, especially at night when there were only two staff to support 30 people. We saw that the staff shift patterns meant that some staff ended their shift at peak activity times. We saw that five people had experienced a delay in receiving their meals at lunchtime. A member of staff told us this was the norm as there were not enough staff at lunchtime. A relative told us, "Lots of new staff." We saw that there were agency staff in use and the acting manager told us that there was on going recruitment of staff and on going consultation with staff to change the shift patterns to better meet people's needs. This meant that at the time of our inspection there was not enough staff to provide continuity of care and meet people's needs appropriately. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that bedroom doors were propped open by stools or bedside cabinets because the attached fire alarm door closures were not in working order. This meant that in the event of a fire bedroom doors would not close and this could put people at risk from fire and smoke. We saw that the hot water temperature from one shower was hot enough to scald people and there were no systems in place to restrict the hot water temperature. This meant that people were at risk of harm because equipment had not been appropriately maintained and checked for safety.

We saw that some people who remained in their bedrooms were not always provided with the appropriate equipment that would have enabled them to summon assistance. During our inspection on two occasions one person

Inadequate

Is the service safe?

attracted our attention so that they could get assistance to pick up things they had dropped and another person regularly got up out of their chair, walked into the corridor and shouted for staff assistance. No risk assessments were in place to show that the individuals were unable to use the buzzer system. This meant that some people were not able to summon assistance easily and may not have their needs met safely.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the people we spoke with told us they felt safe in the home. One person said, "Its good care. I feel safe." All the staff spoken with told us, and training records confirmed they had received training in safeguarding adults and were able to tell us how they would respond to any incidents of abuse. They were aware of the lines for reporting any concerns within the organisation and externally if they felt that appropriate actions were not taken. This showed that systems were in place to protect people from the risk of abuse.

We saw that the principles of the Mental Capacity Act 2005 (MCA) were followed. People's ability to make decisions for themselves had been assessed. Meetings were held to ensure that decisions made were in people's best interests for some but not all issues. For example, there were meetings to decide if the flu vaccine was appropriate for people or whether people wanted to be resuscitated but there had been no discussion about the use of bed rails which could restrict people's movements. The acting manager told us and staff confirmed that training in respect of the MCA had been arranged for staff but not yet carried out. During our inspection we saw that there were long periods of time when some people were left with tables placed in front of them even though they were not being used for anything. This could mean that people were not able to get up and move at will. One person told us, "They are very good here but they don't let me go out for a walk from here." However, we later saw that the person was taken outside for a few minutes to feed the birds. We saw that some applications had been made and authorised by the local authority to protect people under the Deprivation of Liberty Safeguards (DoLS). We discussed with the acting manager and provider's representative about the need for an application to be made in respect of two other people. This meant that not everyone's rights were fully protected.

All the staff spoken with told us that they had completed an application form, provided references of their past work history and had undertaken a Disclosure and Barring Service check to show that they were of good character. The records we looked at confirmed that all the required employment checks were carried out so that only suitable people were employed to work in the home. This meant that people were supported by staff that had been checked for their suitability to be employed.

Requires Improvement

Is the service effective?

Our findings

We saw that people's needs were assessed before they moved into the home so that it was known whether people's needs could be met. We saw that people, or their relatives if they didn't have capacity, were involved in providing information about their needs so that staff knew the about their likes, dislikes and life history of people. A relative spoken with told us, "I was involved in care planning." Staff knew how to support people in an individualised way because care plans contained the information they needed. Staff spoken with had the skills and knowledge to meet people's needs. This meant that staff had information about the person and not just their care needs.

One relative told us, "I'm happy with the care given." Staff told us they had received training to help them meet the needs of people safely. Records showed that not all the staff had received the training they needed and we saw that sometimes training was not put into practice. This meant that people received the care they needed but were sometimes exposed to unnecessary risk.

During our inspection we saw that people were provided with a choice of meals. The menus we were given showed that there were a variety of meals available including some meals that met people's cultural requirements. Although we saw that people had received some meals that met their cultural requirements, choices were not always adequately promoted because the menus displayed on the units did not identify any cultural meals so that people would not know they were available. The provider has told us that people can drinks at any time of the day. During our inspection we saw that people did not always get drinks when they wanted them because they did not know that they could ask for them. We saw that some people had been waiting for a drink since they had got up. One person told us, "I want a cup of tea. Haven't had a cup of tea." Another person told us, "I am diabetic, still waiting for breakfast. Had an injection this morning. I don't know what they are doing half the time." A third person told us, "Can't have a cup of tea till breakfast. This morning it was 10am. Last drink was around 8pm. Can have water." At lunchtime we saw that some people had to wait for support so that they could eat their meals. This showed that people's choices were not always effectively promoted; drinks were not always available when people wanted them and some people had to wait for support to eat their food.

People at risk of malnutrition were referred to the doctor, dietician and speech and language therapists. We saw that advice given by professionals was followed. We saw that where required people's calorie intake was boosted by the addition of cream and butter to foods and the provision of meal supplement drinks. People at risk of choking were provided with thickened drinks and soft and pureed meals so that they could eat and drink safely. This meant that people's dietary needs were met.

We saw that people's health needs were monitored for changes and people were supported to see healthcare professionals as needed. We saw that a variety of healthcare professionals were involved in people's care and advice obtained was followed. We saw that issues such as skin damage was monitored through photographs and regular reviews with specialist nurses so that any required changes to treatment could be identified.

Good

Is the service caring?

Our findings

Most people we spoke with told us they were happy with the care provided and that staff were caring when they supported them but were always rushing about. Two people told us, “They look after you very well,” and “They make me cry with happiness.” We saw staff made efforts to reassure one individual and distract them when they identified that the person was distressed and wanted to go home. During our inspection we saw that staff responded quickly to people’s requests or expressions of distress in a kind and caring way. We saw staff interact with people in a kind and compassionate way.

We saw that people looked well cared for and individual differences were respected and supported. For example, we saw that one person wore a hat as was their preference and some people wore jewellery and had their nails manicured. This showed that people were supported to look well groomed so that they felt good and staff recognised the importance of people’s personal appearance.

We saw that people were supported to make choices about what they wanted to wear and were referred to by their chosen name. Staff told us that they made choices, based on their knowledge of the likes, dislikes and information from friends and relatives, for some people who were unable to make choices for themselves. Staff provided care in a dignified and compassionate way whilst preserving their privacy and dignity. For example, we saw that bedroom doors were knocked by staff before entering and doors were closed when personal care was provided.

Relatives we spoke with told us they could visit when they wanted and we saw that some friends and relatives visited throughout the day. We saw that people had been supported to attend church. This showed that people were able to maintain relationships that were important to them.

One person we spoke with told us they had been asked what help they wanted when they moved into the home. A relative told us that they were asked about their family member’s likes and dislikes because the individual was not able to say for themselves and they were involved in regular reviews about the person’s care. We saw that people were asked what they wanted to do and were able to sit with people they liked. Staff told us and we saw that they asked people and kept them informed of what they were doing during moving procedures. This showed that people and relatives were able to express their views and were involved in making decisions about care.

One person told us that the staff always knocked and waited to be asked in before entering their bedroom. The person also told us that they were spoken with respectfully, referred to by their first name and the door was always closed when they were assisted with their needs. We saw that when staff assisted people they ensured that bedroom doors were kept closed. Everybody that lived in the home had their own bedroom and this meant that they had privacy and a private space in which to sit. Everyone we saw was dressed in clothes that reflected their personality and looked well cared for. This showed that staff ensured the privacy and dignity of people that lived in the home.

Good

Is the service responsive?

Our findings

We saw that people or their relatives, if they were not able to made decisions, were involved in planning care. One relative told us that they had been involved in providing information about their family members needs and was happy with the care provided. The relative told us that they had been involved in reviews about the individual's care needs. This showed that people or their representatives were involved in planning and reviewing the care provided.

We saw that friends and relatives visited people at various times during the day. One relative told us that there were no restrictions on visiting and they were able to see people in their bedrooms if they wished. We saw that some people went out with their friends and relatives. One person's friend visited regularly and spent a lot of time with them in the home because it was the individual's choice not to go out. This showed that people were supported to maintain contact with friends and relatives if they wanted.

We saw that actions were taken to ensure that people's changing needs were met. For example, a sensor mat had been installed in one person's bedroom to alert staff that they were leaving their bedroom at night as they were prone to wander into other people's bedrooms and disturb them.

We saw that there were some activities so that people had meaningful things to be involved in but people did not always benefit fully from them. For example, we saw that one person was provided with a newspaper to look at but there was little support for them to read it. Staff told us that there were not enough activities and opportunities for people to go out. However, during our inspection we saw one person was taken out to feed the birds and later had their nails painted. In the evening one person called out the numbers for a game of bingo that some people enjoyed.

However, for large parts of the day people were sat in bedrooms or in the lounges with few interactions with staff and nothing to occupy them. This meant that there were some activities but they were not sufficient to meet everyone's emotional and social needs.

One relative and a person that received a service told us that they were able to speak to the staff, nurses and managers if they were unhappy. We saw that one person had raised several concerns and they had all been addressed with the individual by the acting manager. There was a complaints procedure in place and we saw that some complaints had been received and responded to. One member of staff told us, "I would raise issues with the nurses or directly with the manager. I think I would be listened to." This indicated that the concerns of people living there, relatives and staff were listened to and responded to appropriately.

A meeting had been organised for relatives to comment on the service provided but no relatives had attended. Records showed and staff confirmed that they attended meetings where the needs of people and better ways of working were discussed. We saw that as a result of comments from staff a second nurse to work during the night had been planned. This showed that there were systems in place to gather people's views so that actions could be taken as a result.

There were systems to ensure that the service worked with other professionals to ensure that people's needs were met. We saw that there were systems to ensure that information was sought from hospitals and social workers when people were assessed to come into the home. We saw that systems to ensure that the required information was passed to other professionals during reviews and admissions to hospital so that people's needs were met and planned for.

Requires Improvement

Is the service well-led?

Our findings

We saw that there were systems to improve the quality of care and implement best practice. For example, training plans were in place to ensure that staff were kept updated with current good practice guidelines. We saw that there was some monitoring of safeguarding reports, complaints, health and safety and medicines, however, the systems did not always result in the required improvements. For example, the room temperature for one medicine storage room was too high for the safe storage of medicines. This had been identified in the CCG report in December 2013 and also by the supplying pharmacy in June 2014 but actions had not been taken to address this. Medication audits did not identify errors in a timely manner so that people received their medicines as prescribed. Staff did not always follow safe moving and handling procedures. Not all the required DoLS applications had been made to ensure that people's rights were protected. Reviews of the environment had not identified that the environment could be enhanced for people with dementia so that it was easier for them to identify where their bedroom, bathroom and toilets were. This meant that although there were systems in place further improvements were needed to ensure that a good service was provided. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The acting manager told us that until June 2014 there had been a voluntary restriction on admissions to the home as there had been some concerns about the quality of service provided. Since then they had worked with other stakeholders and following improvements admissions to the home had begun on a gradual basis.

At the time of our inspection there was no registered manager in post however the registered provider had taken actions to address the shortfall and appointed an acting manager. It was important that there was a registered manager in place so that responsibility was shared with the provider to ensure that the service was well managed.

The acting manager had not been in post long enough to make the necessary improvements but some actions were being taken. The acting manager told us that consultation was ongoing with staff so that shift patterns could be changed so that people's needs were better met. Some staff told us that they were aware of the whistle blowing policy but had not always felt able to raise issues with managers or the provider. However, they were positive that the acting manager was more approachable, willing to listen and take actions where needed. We saw that staff were listened to and actions were being taken in response. For example, as a result of staff comments actions were being taken to ensure activities were available for people in the evenings and weekends. Also as a result of staff comments an additional nurse was being added to the rota. This showed that systems were being put in place so that the service was well managed and there was a culture of openness so that people were able to make their views known.

We saw that the service had worked in partnership with other agencies to ensure that people's needs were met. For example, by taking advice from with health care professionals and local commissioning groups to make improvements. By working with local churches and palliative care teams to ensure that people received good end of life care that met their personal needs. Local workforce placements were facilitated so that apprenticeships were provided with work experiences so that the workforce could be developed. This showed that the service worked well with other agencies.

The acting manager was accessible to staff and relatives if needed by phone and the on call system in the case of an emergency. The acting manager told us that she had an open door policy so that anyone could speak to her if she was available and we saw that the acting manager worked with staff in meeting people's needs on a regular basis so that people could speak to her anytime. This showed that there were open and transparent communication systems available for people to raise concerns.

Staff told us that they knew the lines of responsibility however some staff told us that there were not enough staff meetings and some items they wished to discuss were not discussed due to lack of time. Records we looked at showed that staff had received a job description that showed their responsibilities and they knew their responsibilities in respect of safeguarding people from harm. The provider information return told us that the service had plans to appoint dignity champions and link roles for staff in respect of infection control, tissue viability, nutrition and medication. This meant that staff would be clear about who was responsible for what and that responsibilities would be shared.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services were not protected because the delivery of care did not ensure their welfare and safety. Regulation 9(1)(b)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: Arrangements in place did not ensure that people were protected from the risks relating to their health and welfare because the monitoring of the quality of the service was not sufficiently robust. Regulation 10 (1) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	How the regulation was not met: Suitable arrangements were not in place to ensure that people were protected from risk because the safety of equipment had not been assured it was suitable for its purpose. Regulation 16(1)(a)
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not met: There were not sufficient numbers of suitability qualified staff available to assist people at the times needed.