Lovett Care Limited

Hilton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 August 2017 and was unannounced.

The service was registered to provide accommodation and personal care for up to 55 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 52 people were using the service.

The service had a registered manager. 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.

At the last inspection in April 2016, the service was rated as 'good'. At this inspection we found some breach of regulations. You can see what action we told the provider to take at the back of the full version of the report .

The risks to people were not always suitably assessed and managed. Staff knew people well but their risk assessments and care plans did not always contain enough up to date information to ensure they received consistently safe care.

Staff knew how to protect people from harm and abuse but the systems in place to ensure that allegations of abuse and harm were investigated were not always operated effectively. Suitable plans to reduce the risk of repeat incidents were not always put into place.

The principles of the Mental Capacity Act 2005 were not consistently followed to ensure that people's rights were upheld.

Systems in place to monitor the quality and safety of the service were not always effective to ensure that issues were identified and acted upon to improve the quality and safety of the service.

There were enough staff to meet the needs of people who used the service and this was regularly reviewed by the registered manager and provider.

Medicines were safely managed, stored and administered to ensure that people got their medicines as prescribed. Staff were suitably trained and supported to meet people's need.

People with provided with enough food and drink to maintain a healthy diet. People had choices about their food and drinks and enjoyed the food and drinks on offer.

People's health was monitored and access to healthcare professionals was arranged when required.

People were treated with kindness and compassion and they were happy with the care they received. People were encouraged to make choices about their care and their privacy and dignity was respected.

People had support to meet their individual needs and preferences and were offered opportunities to participate in activities that interested them. People were supported to have care plans that reflected their preferences and staff knew people well.

People knew how to complain if they needed to. A complaints procedure was in place and complaints were dealt with in line with the procedure.

People, relatives and staff felt that the registered manager and providers were visible in the home and felt they were approachable. They promoted an open and inclusive culture where people and staff felt involved in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's risk management plans did not always suitably manage their risks to ensure they received consistently safe care.
Staff knew how to protect people from harm and abuse but systems in place to ensure that allegations were investigated were not operated effectively.
There were enough staff deployed to meet people's needs and people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 were not always consistently followed to ensure that people's rights were upheld.
Staff had the knowledge and skills to support people effectively.
People had support to eat and enough to maintain a healthy diet.
People had access to healthcare professionals when they needed them.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and were encouraged to make choices about their care and treatment.
People's privacy was respected and staff provided care in a dignified way.
People were happy with the care they received and told us that staff supported them in a caring manner.

Is the service responsive?

Good

The service was responsive.

People received care that met their individual needs and were given opportunities to participate in activities that interested them.
People were supported to have care plans that included their

likes, dislikes and preferences so that staff could provide support in the way they preferred.
People knew how to complain and complaints were recorded and managed in line with the provider's procedure.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

Systems in place to monitor the quality and safety of the service were not always operated effectively to ensure that issues were identified and acted upon to improve quality.
There was a registered manager and people knew who they were and felt able to approach them with any issues.
The registered manager and providers were visible within the service and promoted an open and inclusive culture for people and staff.
Feedback was sought and acted upon to make improvements to the service.

Hilton 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 inspection took place on 31 August 2017 and was unannounced.

The inspection team consisted of three inspectors, an expert by experience who has personal experience of caring for someone who uses this type of care service and a specialist advisor who has specialist knowledge about supporting people to move safely.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed the information we had received from the public and the local authority. We used this information to help formulate our inspection plan.

We spoke with 13 people who used the service and six visiting relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with seven members of care staff and three visiting healthcare professionals. We spoke with the registered manager and providers to help us to understand how the service was managed.

Some people who used the service were not able to speak to us about their care experiences so we observed how the staff interacted with people in communal areas and we looked at the care records of nine people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included five staff files, training records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People's risks were not always suitably assessed and managed to protect them from harm. The registered manager told us that one person was at very high risk of falls. We looked at their risk assessment and management plan and saw they were assessed as medium risk of falls despite having fallen ten times in the last two months. Of the ten falls the person had experienced, only five of these falls were recorded on accident forms which meant that a clear picture of the person's falls would not be obtained when being reviewed to look for trends and triggers. We saw that the person's risk assessment was being reviewed monthly. However, no changes were made to minimise the on going risk of further falls, though we saw that staff took appropriate action when people experienced falls. The person had been referred and reviewed by a Physiotherapist following the falls, so some action had been taken to manage their risks. However, the recommendations of the Physiotherapist had not been incorporated into the person's care plan. This meant the person was a risk of receiving inconsistent care to manage their risks.

A person who used the service displayed some behaviour that challenged such as verbal or physical aggression and this was recorded in their daily notes. We found that behaviours were not always effectively assessed and planned for to promote the person's safety and wellbeing. Staff told us and the person's daily records confirmed that at times the person displayed behaviour that challenged, however there was no management plan in place to guide staff on how to support the person with this. This meant there was a risk of the person receiving inconsistent care which may place themselves or others at risk of harm.

We found that one person was at risk of choking. Their risk assessment said they had been referred to a Speech and Language Therapist (SALT) who had assessed the person as requiring a pureed diet and normal fluids to manage their choking risk. A corresponding care plan confirmed this. We saw additional notes in the person's care plan that stated they required sips of fluid from an open cup and that they were not to be left alone whilst eating and drinking. We observed the person was given cornflakes and a drink in a lipped cup at breakfast time. This did not follow the risk management plan. Staff told us that the person's cornflakes were soaked and this made it safe for them to eat. However, this wasn't reflected in the person's risk assessment or care plan and it appeared that staff didn't follow the risk assessment and care plan in place to keep people safe from harm. This meant that risk management plans were not robust to ensure the person received consistently safe care.

The above evidence demonstrates that risks were not always suitably assessed and managed to ensure that people received consistently safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and professionals we spoke with told us they were confident people were safe at Hilton House. People's comments included, "They keep us safe" and "I feel very safe here, safer than at home." A professional said, "I trust people are safe." Staff knew how to protect people from avoidable harm and abuse. They were able to explain the types of abuse that may occur and how they would recognise signs that may give cause for concern. Staff told us how they would report concerns to ensure that necessary investigations were completed. One staff member said, "I would report to the senior who reports straight up

the management."

We saw that a safeguarding record was in place which contained allegations of abuse that had been reported by staff. The registered manager told us that an incident record was completed by staff and then passed to the registered manager to review following initial information gathering that was completed by the assistant manager. However, the safeguarding record in place did not clearly show when concerns had been reported to the local authority and what plans were in place to protect people from harm and abuse reoccurring when required. Some incident logs had not been signed by the registered manager to show they had been reviewed and suitable protection plans put into place. For example, a record in the safeguarding log showed that one person had kicked another person causing a cut that required medical attention. The registered manager told us they had reported this to the local authority but they could not locate the records to confirm this. We could not see what plans were in place to reduce the risk of further incidents occurring. This meant that systems and processes were not operated effectively to investigate allegations and prevent abuse.

There were enough staff to meet the needs of the people who used the service. One person said, "You ask for something and you get it. They come quickly." Another person said, "When I'm in bed the girls pop in regularly to check I'm okay, it makes me feel safe. I like the security of people." We saw that when people requested support, staff responded to them in a timely manner. Staff told us there was enough of them to meet people's needs and that when shifts needed to be covered, they were willing to volunteer. One staff member said, "There's enough staff available. We permanent staff cover all the shifts; I've never seen any agency staff." The registered manager told us and we saw that they regularly assessed the level of needs of people who used the service and this informed the number of staff on duty. This was called a dependency tool and helped to determine the number of staff needed to meet people's needs. We saw that the number of staff on the rotas and on duty exceeded the number recommended by the tool. This meant that the registered manager and provider had ensured there were enough staff available to meet people's needs.

Staff told us and we saw that safe recruitment practices were followed. This included references and Disclosure and Barring Service (DBS) checks to make sure that staff were safe and suitable to work at the home. The DBS is a national agency that keeps records of criminal convictions.

Medicines were managed safely so that people received them when they needed them. People we spoke with told us that staff supported them to take their medicines safely. We observed that staff administering medicines wore a 'do not disturb' tabard. This ensured that staff gave the medicine administration their full attention and reduced the risk of error. Staff took medicines to people who required them and explained what their medicines were for. They ensured that people swallowed their medicines before signing records to say they had been given. Medicines administration records showed that people were supported to take their medicines as prescribed. Staff who completed medicines administration had been trained to do so and their competency had been checked before they administered medicines alone. Systems were in place to ensure that medication was stored, managed and administered safely and we saw that these were effective.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw and people told us they were asked for their consent before they were supported by staff and when they were able to, they were encouraged to make their own decisions. Staff we spoke with were able to demonstrate that they understood the principles of the MCA and how to apply these to ensure that people consented to their care when they were able to.

However, records we looked at did not demonstrate that the MCA was always being followed correctly. One person was admitted to the home in May 2017. Their care plan did not contain any evidence of consent to the care they were receiving and their mental capacity to consent to this had not been considered or assessed. We asked staff about this and they told us it was because the person was new and that an assessment of their capacity to consent to their care would be completed soon. However, the person had been living in the home for three months and there was a risk they were receiving care they had not consented to. We saw other examples that showed the MCA had not been applied correctly. We saw that one person had been assessed as having mental capacity to make decisions about their care planning. However, staff had then recorded a best interest's decision to say that it was in their best interests to receive the care detailed in their care plan. However, if the person had mental capacity, staff should not have been making this decision for them. This meant that the principles of the mental capacity were not being followed correctly to ensure people's rights were protected.

We saw that when people were as assessed as lacking mental capacity to be involved in care planning there was a record of a best interest's decision that stated it was in their best interests to receive care as detailed in their care plan and to take medicines as prescribed. However, these best interests' decisions did not detail who had been involved in the decision making, and were not decision specific as the MCA required. We saw the same generic best interest decisions recorded for a number of people. One person had a best interest's decision recorded in June 2016 with the same generic statement about receiving care and medicines in their best interest. However, their subsequent daily records showed that they were often resistive personal care and that it caused them some distress but the best interest's decision made in June 2016 had not been revisited to ensure that it remained in the person's best interest to receive daily personal care even though it caused them distress. This meant the principles of the MCA had not been followed correctly to ensure that the person's rights were upheld.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. We saw that some people had DoLS authorisations requested when required. However, one person was assessed as having mental capacity to make decisions about their care planning

but we saw that this person had a DoLS authorisation in place. This suggested that the principles of the MCA had not been fully understood or followed correctly.

These issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were provided with training to help equip them with the skills and knowledge to provide effective care. One person said, "The staff are marvellous here." Staff told us they were provided with a thorough induction which included online and face to face training. One staff member said, "After [the induction training] I shadowed for three shifts, then I felt ready to provide care. I observed care being provided and asked a lot of questions so I knew [what to do]." Staff told us and records confirmed that regular training was provided. One staff member said, "The training is thorough, like everything here. I did moving and handling training at the beginning and I've had updates since, no matter how long you've been here you still get to update." Staff felt well supported in their roles and had access to regular supervision and support from the registered manager and providers. A staff member said, "We have supervision and we can give our opinions and get feedback. Development opportunities and qualifications are resourced by the provider." This showed that staff were supported and encouraged to develop their knowledge and skills in order to provide effective care.

People told us and we saw they enjoyed the food on offer. One person said, "The food is lovely, I wouldn't want to go home at all." We saw that people were encouraged to make decisions about what they ate and drank as staff asked them what they would like and there was a pictorial menu on the wall for people who needed these visual aids. We also observed that the provider showed people the lunch time options available by presenting two plates of food so that people could see what was on offer and make an informed choice. Meal times were well organised so that people got the support they needed, when they needed it. Hot and cold drinks were readily available and snacks were offered throughout the day including fruit and biscuits. This showed that people were supported to eat and drink enough to maintain a balanced diet. When people's intake of food and drink needed to be monitored because of concerns for their health, we saw this was done and regularly reviewed and discussed at weekly meetings to ensure that action was taken and referrals to professionals were made as required.

People were supported to maintain good health and had access to healthcare professionals when they needed them. One person said, "Yes, staff make me a GP appointment." Another person said, "There's a doctor on call, we can see them anytime, I see the chiropodist too." We saw that referrals were made for people to access healthcare support when required. When further advice was needed from professionals, we saw that staff actively sought professional input to get the best outcomes for people. For example, one person was assessed by a Speech and Language therapist (SALT) as needing thickener in their drinks. They told staff they did not like this and we saw that staff referred back to the SALT who assessed that the person had the capacity to make this decision and they had normal drinks. Staff told us and records confirmed that the person's fluid intake had increased as a result of this. This meant that the person was supported to maintain good health with access to healthcare services.

Good

Is the service caring?

Our findings

People told us and we saw they were treated with kindness and compassion. People's comments included, "It's lovely here. The staff are good, very helpful. They look after you properly," "The carers are so caring with me," and "I'm one of the family here, it is one big happy family." We observed that staff showed concern for people's wellbeing in a caring manner. We saw staff checking whether people were too hot when they were wearing jackets or jumpers and staff regularly asked people how they were feeling and took action to make them comfortable when required. We saw one staff member holding a person's hand whilst they chatted to them, the person was smiling and enjoying the chat, they commented to us, "[Staff member] is lovely." This showed that staff had positive and caring relationships with people who used the service.

People told us and we saw they were supported to make choices and decisions about their care. At meal times, people were shown the options available to them to help them make an informed decision. People were asked about where they would like to sit and how they would like to spend their time. We saw that the service had a dementia friendly garden with a path that led back to the main area so that people could be as independent as possible when accessing the garden. We saw that some people accessed the garden independently as they wished and others were supported to access the area by staff. People were asked whether they would like to have some fresh air and spend some time outside and were supported to do so when they wanted to. Staff took cups of tea outside to people and checked they were comfortable, providing blankets when needed. This showed people were offered choices and supported in a caring manner to do what they chose.

People told us and we saw they were treated with respect and their dignity was promoted. One person said, "The carers are marvellous. They treat me with so much respect; I can go to them if I need to." Another person told us, "I need help to use the commode and the carers are great, they don't make me feel embarrassed." We saw that staff were proactive in protecting people's dignity. For example, when people needed assistance to eat, they were supported discreetly at a table in a quiet area of the dining room. An assistant manager told us that protected mealtimes were operated which meant that visitors were requested not to call at mealtimes so that people's dignity whilst eating was protected and people felt comfortable and had the time they needed.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs and preferences. People told us and we saw they could spend their time how they chose to. One person said, "I like to go to bed at 10pm, I can choose." We saw one person reading a daily newspaper and another person reading a book. They told us, "As long as I can sit and read I am happy and I can do that here. I've always been a big reader." Some people chose to watch the television and we saw they enjoyed chatting with others and discussing the programme they were watching. We saw one person using the door code to go outside for a cigarette as and when they pleased. This showed that people were supported to have choice and control.

People were encouraged and supported to participate in purposeful activity within the home. We saw one person gathering napkins together and helping the provider to set the tables for lunch. Staff commented on what a good job they were doing and thanked them for helping. We saw the person took pride in what they were doing. We saw another person dusting the shelves in the communal lounge; staff provided them with a duster and told us the person enjoyed helping staff and being involved in the service. One person was helping to clear the tables after lunch time and we saw they were enjoying being involved and having a role within the home. This showed that people were supported to be involved in the service and participate in activities that were meaningful to them.

People were supported to follow their interests and take part in social activities. One person said, "I like to go to the hairdressers, I like to do competitions and to chat to people, I'm quite sociable." A musician came into the home and we saw people enjoying singing and dancing along and that staff encouraged people to join in and socialise. One person said, "I really enjoyed the music, it brought back happy memories." A visiting professional said, "People get a bespoke, individual service." Another professional said, "People get person-centred care. It is positive, warm and friendly; a home for people."

People were supported to receive care that reflected their likes, dislikes and preferences. For example, one person's care plan contained detailed, personalised information about how they liked to be supported with their personal care. It encouraged their independence as it detailed what the person was able and liked to do for themselves and what they needed support with. It explained their preferences including how they liked to look and we saw they were supported in line with this. Staff knew people well and demonstrated a good knowledge of their preferences, like and dislikes. For example, a staff member told us, "[Person's name] always drinks their tea immediately; we say [Person] must have an asbestos mouth." The person was laughing and joking with staff and said, "I like my hot drinks hot!" This showed that staff knew people's preferences in order to help them provide personalised care and support.

People and relatives told us they knew how to complain if they needed to and they would feel able to do this if required. One person said, "I would complain to the office." There was a complaints procedure in place and staff demonstrated that they knew how to respond to people's concerns or complaints. One staff member said, "I would get all the information for an investigation and pass to the registered manager, we have 28 days to give an outcome to the complainant." We saw when complaints were received they were logged and dealt with in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes were not always operated effectively to assess, monitor and improve the quality of the care provided. Monthly care plans reviews were completed by assistant managers but these did not effectively identify when improvements or changes were required to the quality and accuracy of the care plans. We found that some people's risk assessments and care plans did not contain up to date, detailed information in order for the risks to be managed. However, care plan reviews had not identified the issues and therefore action had not been taken to improve quality. For example, one person had experienced a number of falls but their care plan and risk assessment had not been updated to accurately record how the risk was being managed. Other people had generic best interests decisions recorded which did not comply with the Mental Capacity Act 2005 but the care plan reviews had not identified the issue and no action had been taken to review this. This meant that the quality assurance systems in place were not effective.

We found that people had DoLS authorisations in place when these were required but they were not always kept in the persons care files and so could not be easily accessed by staff. When we asked to view a person's DoLS authorisation, the information was not readily available and the registered manager had to locate the authorisation and print a copy out for us to view. This meant that staff did not have access to information about any conditions of the DoLS authorisations so they could ensure these were met. The registered manager did not have an up to date list of people who had DoLS authorisations in place, including their expiry dates so that it was easy to track who had authorisations in place and when they were due to expire that so new applications could be promptly requested if required. This meant there was not an effective system in place to ensure that people's DoLS authorisations were up to date so that their care was delivered safely and effectively. When we spoke to the registered manager about this, they told they would implement a tracker for DoLS applications to enable them to keep track of the DoLS authorisations in place.

Some people had 'skin bundles' in place which recorded how risks to people's skin were being monitored and managed. Weekly audits were being completed by assistant managers to check these were effective. However, we saw the audits were just ticks to say that records had been looked at. They did not contain evidence of any action required or taken. For example one person was declining personal care but it was not clear to see what action staff needed to take when the person declined personal care to ensure the person received the care they needed to manage the risk to their skin. This meant the registered manager and provider could not be sure these audits were effective.

A person who used the service required Antecedents Behaviour Consequences (ABC) Charts to monitor their behaviour and assist in identifying triggers and trends so that risks could be suitably managed. These charts were requested at a social care review of the person's needs to ensure their needs could be accurately assessed. We saw that these records were in place but were incomplete. We saw that 12 incidents of behaviour including spitting at staff, aggressive behaviour to staff, punching and kicking at staff were recorded in the person's daily notes. Nine of these were not recorded on an ABC chart so it was not clear to analyse any triggers and have an accurate record of the person's needs and risks. ABC charts that we did see included incidents that were not recorded in the daily notes so there was inconsistency of recording, meaning there was not a clear picture of the person's behaviour. The registered manager was not aware of

this inconsistency in recording until we bought it to their attention. The registered manager looked for additional ABC charts as they felt confident that staff would have recorded all incidents as required, however these could not be located.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew who the registered manager and provider were and we saw they had an active presence within the home, creating an open and inclusive culture. One person said, "I can speak to [Registered Manager's name] about anything and they're always there for me, even if they're busy." Another person said, "I get on well with [Provider's name]." We saw that the providers took an active role at the home, supporting people, chatting with people and helping staff. Staff told us that the registered manager had worked a night shift when staff were not available and the providers had covered shifts in the kitchen. One staff member said, "The management will chip in. They're not scared of getting their hands dirty, on the floor or in the kitchen, wherever they're needed." Staff appreciated the providers' active role within the home. One staff member said, "It sets a good example when they all help out. The provider is always here and always about speaking with people." Another staff member said, "It's good that [the providers] help out. We feel reassured that they understand. They know people well."

People's feedback had been sought via a staff, visitor and professionals survey which had recently been carried out and the results were positive. One person said, "I would recommended it here, it's lovely." Staff told us they were encouraged to give their feedback formally and informally and that it was listened to. A staff member said, "[The Provider] is always asking for feedback. I feel listened to by all the management team." The staff member shared an example of how they fed back concerns to the provider about a new food supplier. They told us their concerns were listened to and taken seriously and the provider changed back to a previous supplier that people preferred. This showed that people's feedback was encouraged and listened to and actions were taken to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 were not consistently followed to ensure that people's rights were upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always suitably assessed and managed to ensure they received consistently safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not always effective to ensure that issues were identified and acted upon to make improvements when required.