Avonpark Village (Care Homes) Limited

Hillcrest House Care Home

Inspection report

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Date of inspection visit:
22 February 2017

Date of publication:
18 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At the last comprehensive inspection found breaches of the legislation. We took enforcement action, served warning notices and imposed conditions on the registration of this service. Following the inspection the provider developed a comprehensive action plan to meet the imposed condition of registration and to address the warning notices and other requirements where there were breaches of the regulations.

This inspection was unannounced and took place on the 22 February 2017. Hillcrest House can provide accommodation and personal care for up to 34 people living with dementia. At the time of our visit there were 11 people accommodated.

People told us they felt safe with the staff and we observed that people's behaviours indicated they were happy for staff to approach them. The staff knew the aims of the safeguarding of vulnerable adults procedures. The staff knew the types of abuse and the responsibilities to report abuse where it was suspected.

Contingency plans and individuals evacuation procedures in the event of an emergency were in place. The contingency plans needed reviewing to ensure the contact details of staff currently employed were included. The plans detailed the contact details of the registered manager and contractors in the event of an emergency.

Mental Capacity Act (MCA) assessments for some people needed reviewing to ensure the best interest decisions were relevant to the specific decisions that was being made. We saw for example, that consent for photographs to be taken was gained from a relative without power of attorney. The MCA assessments lacked detail and action plans on the best interest decisions reached were not always in place.

Care plans were overall person centred and provided insight that people were living with dementia. However, action plans lacked detail on how staff were to meet the identified needs. We found information was duplicated and at times was not consistent and was contradictory. This may mean that staff were not provided with clear guidance on how to meet the needs of people. Activities were not taking place consistently to ensure people were able to pursue their interests.

The staffing levels met the basic needs of the people living at the service. Staff said that agency staff were used to maintain staffing levels. We were told that the same agency staff were used which improved consistency to people. Staff said staffing levels did not allow for staff to take people out in the community.

The provision of training had improved. This ensured that staff had the skills to meet people's needs. There were opportunities for staff to undertake vocational qualifications. Staff were registered onto the Care Certificate. Staff told us there were opportunities for career progression within the organisation.

People's dietary requirements were met. There were choices of meals and refreshments and in between meals there were snacks and refreshments available. We observed the lunchtime meal and we observed staff helping people to eat and drink and encouraging others to eat their meal.
Relatives told us where there were concerns these were raised with the unit manager. Where people were able they told us concerns were raised and addressed.

Quality assurance systems were in place. Feedback from relatives was being sought on the quality of the service. Social care professionals told us there had been improvements in the quality of the service. Members of staff told us the team worked well together and they were supported to meet the requirements of their role. An agency worker told us information was more accessible.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Members of staff were able to tell us the safeguarding of vulnerable from abuse procedures including the types of abuse

Staffing levels were maintained with agency staff. Permanent staff said the same agency staff were used at the service.

Risks were assessed and action plans developed to minimise risk.

Safe systems of medicine were found.

Is the service effective?

Requires Improvement

The service was effective.

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was not always assessed.

Members of staff attended training the provider had set as essential. One to one meeting with the line manager to discuss performance, issues of concern and training was in place for all staff.

People had access to health care professionals for their ongoing healthcare needs.

Is the service caring?

Good

The service was caring.

People received care and treatment from permanent staff that knew their needs and respected their human rights.

Members of staff were respectful and consulted people before they offered support

Is the service responsive?

Requires Improvement

The service was not responsive

People's needs were assessed but care action plans lacked detail. Care plans were duplicated and inconsistent with each other. Care plans were not consistently person centred as they did not give staff direction on how people liked their care needs to be met

There was an activities programme in place but activities were not always taking place.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Records were not always up to date, information was inconsistent in care plans and some reports lacked detail.

The provider had developed effective systems to assess, monitor and improve the quality of care.

Staff felt they were supported by management to raise concerns or question practice.

The views of relatives were gathered on the quality of the service.

Hillcrest House 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 22 February 2017. At the time of the inspection there were 11 people living at the service

The inspection was conducted by two inspectors and two Experts 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.'

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We used a number of different methods to help us understand the experiences of people who use 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.

We spoke with seven people who use the service and one relative about their views on the quality of the care and support being provided.
We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included five care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we spoke with the regional manager, the registered manager, and two care staff, which included agency workers

Good

Is the service safe?

Our findings

At the comprehensive inspection of May 2016 we took enforcement action and served warning notices on the provider. We found that people were placed at risk of harm because members of staff were not taking the necessary steps to mitigate risk to people when they were delivering personal care. Equipment to support people was not available. Medicine systems were not safe and placed people at risk. Where staff had raised concerns from incidents and accidents that occurred they were not taken seriously and acted upon.

We undertook a focused inspection in August 2016 to check the provider had met the warning notices. We found the provider had taken action to address the issues highlighted in the warning notices.

On the day of the inspection there was one permanent member of staff with two agency staff and an agency senior in charge. They said an activities coordinator was employed to provide activities. An agency worker told us there was an induction which included a familiarisation of the property and fire procedures. This agency worker stated there was an expectation they attend handovers at the start of their shift.

Medicine audits had been undertaken by the manager. We looked at the latest audits dated 30/01/2017, where minimal issues were noted. During previous audits where actions had been identified, these had been addressed, for example, the ordering an up to date British National Formulary, a drug information book, and the need for competency assessments for all staff that were administering medicines. Medication incidents were reported and investigated in full.

Documentation was in place in relation to three people who were receiving their medicines covertly ("disguised" in food or drink). Two of the three people had completed documentation in place that showed clearly how the decision to administer covertly had been reached.

There was evidence that people's GP had been involved, along with staff, advocates and that the pharmacist had also been asked for advice in relation to whether it was safe to crush the medicines. However, the records for one person were incomplete. Although a staff member had documented "Discussed with GP" on 07/07/2016, the GP had not signed the form to indicate that they agreed with the decision. In addition, the form listed two medicines which the pharmacist had signed to confirm it was safe to crush them. When we looked at the person's MAR chart, they had been prescribed an additional three medicines, but there was nothing documented to show that the pharmacist had agreed to these being crushed. Crushing medicines can alter the way they work which is why it is important to gain pharmacist approval prior to doing this.

We saw people accept support from staff and their behaviour did not indicate distress. We saw people smile as staff approached. The people we asked made the following comments "I like living here," "yes I feel safe here" and "It is a pleasant place". It was evident from our observations that people knew the staff well. Staff were very vigilant of people in the communal areas and responded quickly to people's needs and requests in the communal areas.

A member of staff told us the aim of the safeguarding of vulnerable adults procedures. This member of staff told us the types of abuse and that they reported their concerns to their line manager.

The staff were knowledgeable about the actions needed to minimise identified risks. A member of staff told us the actions taken to minimise risk. They said risks were assessed and action plans developed on how to reduce the risk. It was also stated that moving and handling risk assessments included guidance on using the hoist, the types of slings and for some people the slide sheets to be used to reposition in bed. For people at risk of choking the staff monitored food and fluid intake.

The falls risk assessment was reviewed for a person assessed at high risk of falls. The safe environment care plan described the assistance needed from staff and included was the equipment needed with transfers. Staff were given guidance to reassure the person when they became anxious during moving and handling manoeuvres.

People at risk of weight loss or malnutrition were assessed using the Malnutrition Universal Screening Tool (MUST). The MUST score was included in people's care plans and for one person supplements were prescribed to help this person to maintain their weight. Waterlow assessments were completed to identify people at risk of pressure sores. The Waterlow assessment for one person stated they were at high risk of developing pressure sores because of their mobility impairment and medical conditions. The Tissue Viability care plan for this person gave staff guidance on how to identify pressure damage, the healthcare professionals involved and the topical medicine prescribed. The body map indicated the areas of the body the staff were to apply the topical cream.

Contingency plans in place were in need of reviewing to ensure the correct contact details of the registered manager. Emergency contractors and the location of the mains for utilities were included within the contingency plans.

Individual fire evacuation procedures were in place. The support needed from staff, the equipment and the behaviours that may be exhibited by the person in the event they need to evacuate the property quickly. For example, for one person a wheelchair was to be used to evacuate the property and the person was likely to become distressed and show aggressive behaviour towards staff.

We saw safe recruitment and selection processes were in place. We looked at the file of one member of staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

At the comprehensive inspection in May 2016 we found the principles of the Mental Capacity Act 2005 were not followed by the staff for people who lacked capacity to make decisions. Relatives were able to give their consent for care and treatment when they did not have the legal powers to make these decisions. Members of staff did not have the training needed to undertake their roles and responsibilities. Permanent staff did not have opportunities to discuss performance, concerns and training needs with their line manager. Agency and relief staff were not provided with sufficient information to meet people's needs.

Following the last inspection we received an action plan telling us how improvements were to be made. This action plan stated that people's capacity to make specific decisions was to be assessed and the best interest decisions taken. Where we made requirements on training the action plan stated that "all staff are to undertake mandatory training as per their role (Including Incident reporting and recording, record keeping, Safeguarding, Manual handling and Mental Capacity Act (MCA).

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

People can only be deprived of their liberty 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).

The menu in the dining room was not consistent with the meals served that day. We asked various members of staff who was responsible for changing the menu day to day and no one knew. This may be confusing to people who were expecting to eat the meals on the menu. We observed eight people have their lunch in the dining room. People were asked to make a choice of refreshments. People were served the first course of soup with bread rolls and butter. However some people were not able to open the butter pack. We also noted that staff did not always tell people the flavour of the soup placed in front of them. Members of staff told us for the main course people were shown the meal options. This practice was confusing for some people because as people made the decision on the options shown the member of staff then placed the meal in front of the person. This meant the other people at the table were confused about the options available. For example, a member of staff asked one of four people sat at a table "would you like the lamb or the duck?" and this person replied "I would like the duck please". The member of staff then placed the meal in front of the person. This member of staff then asked the second person their choice of meal but this person then assumed there was only one option available as the member of staff was not holding two meals.

In the lounge one person was having their lunch and told us they hadn't been well and didn't have an appetite. This person refused all meals offered from the lunch menu but staff persevered and eventually

they agreed to have a bowl of cornflakes which this person enjoyed as well as the dessert. One person was asleep in their room. We observed a tray of food left at 12.46 and at 2:15pm when we checked again the meal was untouched. A member of staff removed the tray when it was drawn to their attention. They said "[the person] shouldn't have had it there that long" This member of staff explained the person could take up to two hours to eat a meal sometimes. We were told another meal was to be offered and the member of staff went to get another meal.

We observed staff speaking to people while serving refreshments. Staff offered each person a choice of refreshments which included tea or coffee and chocolate brioche or sausage roll. Two people declined tea and coffee and were brought a jug of squash. We saw staff offer assistance to have regular refreshments.

For one person an MCA was in place to administer medicines covertly [disguised in food or fluid]. The assessments stated the person lacked insight into their conditions and lacked understanding of the consequences for not taking their medicines. The mental health team, GP and the relative with Lasting Power of Attorney reached the best interest decision to administer covert medicines.

We saw members of staff enabling people to make choices about their meals and about activities. A member of staff said people were given choices. They said some people at the home were not able to verbally tell staff the decisions taken. They said the options were shown to the person which helped them make decisions. For example, choices of meals were shown for people to make decisions on their preferred meal.

Training and supervision ensured the staff were supported to meet the responsibilities of their role. Staff said they had access to vocational qualifications and were currently undertaking the Care Certificate. The training matrix included the types of training the provider had set as mandatory for the staff to attend which included moving and handling, safeguarding of vulnerable adults and infection control. Members of staff had to also attend dementia awareness and Mental Capacity Act (MCA) training, and where appropriate medicine competency. Training records showed five of the eight staff employed had attended MCA training.

The registered manager told us there was an expectation that each staff had six one to one meetings per year with the line manager. A member of staff said there were regular one to one meetings with the unit manager. This member of staff told us one to one meetings were monthly with the unit manager and during the meetings they discussed concerns, training and work performance.

People were supported by social and healthcare professionals with their ongoing healthcare needs. A member of staff told us there were regular weekly visits from the GP. Another member of staff said a record of GP visits was maintained and at handovers staff were made aware of changes in people's health and the advice from GP. Visits from social and healthcare professionals were recorded and confirmed people had regular visits from chiropodists and regular dental check-up where appropriate. The reports of visits showed one person had regular visits from the district nurses. The reports included a description of the nursing interventions undertaken.

Good

Is the service caring?

Our findings

We observed staff talking with people about recent and upcoming events and about the local area. One member of staff spoke to one person about the weekend which made them smile. Another member of staff spoke with another person about the weather and local places known to the person, while another staff was talking about lunch and when this was. People were responsive and enjoyed the interaction.

A member of staff said there were opportunities to discuss with people their histories, likes and dislikes. Where people were not able to give information about their background the staff gathered the information from relatives. It was also stated that lifestyle profiles provided life stories based on people's background histories, family involvement and leisure activities. This will ensure staff have insight into the person which ensures they were viewed as individuals.

There was good interaction between staff and people. We observed a member of staff use a reassuring and calm manner when one person woke up from sleep and was disorientated. We also observed another member of staff assisting one person to have a drink. This member of staff used a calm approach and was interested in the conversation with the person. When speaking to people staff were at eye level. We saw staff kneeling on floor to be on the same height as the person sitting on the chair. The staff talked to people continually and received a positive response. One person asked a member of staff for a sweet and was given one.

A relative told us that staff were respectful of their family member. They stated "oh yes, staff are very respectful" and "they talk to her nicely and always ask her, rather than telling her. They always knock on Mum's door".

Staff were aware of people's rights and gave us examples on how they respected these rights. A member of staff said giving people space was important and recognising some people may want time to be alone. It was also stated that ensuring people's personal care was in private and that people were dressed appropriately for the weather and in their preferred manner respected their dignity.

Points of interest to help people find their way around the home and to enable people to orientate themselves on their location in the building. There were personalised memory boxes on bedrooms doors, with photos or ornaments in them which helped people recognise their bedrooms. There were chairs at intervals in hallways this helped people take breaks. The dining room was freshly decorated, with an adjoining small lounge. It was clean and had a brightly painted mural on one wall. We saw two people looking at the mural with pleasure during the course of the day, one in the morning, and then at lunch. There was an enclosed outside area, with a door with a keypad, and with plenty of seating for residents.

A member of staff said visitors can visit anytime. A relative said "there are no restrictions on visiting - I pop in whenever I can, usually twice a week" and "I don't visit on the same days, whenever I can get here". She said "I don't usually tell the staff when I am coming, in case I can't make it".

The End of Life care plan for one person stated a Do not attempt resuscitation (DNAR) order was in place. Within the care plans was the person's preference on who to inform in the event of their impending death and their wish for their death to be pain free. For another person their End of Life plan included their funeral arrangements, their wish for staff to attend the religious service and for their death to be pain free.

Requires Improvement

Is the service responsive?

Our findings

At the comprehensive inspection in May 2016 we found care plans were not developed for all areas of need and they lacked detail on how staff were to meet people's needs in their preferred manner. We received monthly audits telling us the improvements made and where standards were not fully met the action to address the shortfalls. The monthly audits that we had received told us that the improvements to the care planning process were ongoing and had not been completed. We confirmed this at the inspection.

The lifestyle profile for one person described their family, past employment, hobbies and routines for example the preferred times to rise and retire. However, life stories were not in place for two people. This meant staff were not given information about the person which established them as individuals and separate from other people living at the service.

Assessments of people's care and treatment needs were undertaken during the admission process. Peoples health, personal care, emotional, social, and spiritual needs were assessed. For one person their assessment included their communication needs and how the dementia diagnoses impacted on their behaviour.

A relative said "I am not sure as mum has only been here for a month but I think the GP does them". She also said "They involve me in any decisions about mum" and gave an example of a recent decision that was made regarding a continence issue.

Care plans were duplicated in places, the information was inconsistent and conflicting. For example, for one person part of the same information was included in the personal care plans, behaviour and mood care plan, mental state and cognition care plan, mental capacity care plan and mental health care plans. The registered manager told us new care plans were due to be introduced. The pain care plan for another person informed staff to monitor behaviour changes and report them to seniors as it may be a trigger of pain. There was a lack of detail on the behaviour changes that would indicate to staff the person was in pain. The behaviour plan did not include that some behaviours may be a indication of pain.

Care plan were inconsistent. The behaviour care plan for this person exhibited unpredictable behaviour and at times became physically challenging. The action plan instructed staff to remove obstacles, provide one to one support and record the incident. While the types of behaviours exhibited were part of the mental state care plan these behaviours were not identified in the behaviour care plan. The action plan for this care plan was for staff to give the person time and explain the task. This guidance was missing from the behaviour care plan. The mental health conditions stated the person had many high risk conditions. Staff were to deliver one to one support and report new symptoms and seek professional advice. However, where symptoms had an impact on behaviours this was not included in the behaviour care plan or the mental state care plan. This meant staff may not be aware of all the information if all care plans relating to behaviours were not read.

The Tissue Viability care plan for another person stated that a bruise had been "noted". A body map was completed to show the location of the bruise. The action plan was for the staff to administer pain relief when

needed by the person. The care plan lacked detail on the progress of the injury and if bruising had faded.

The behaviour care plan for one person informed staff that the person may become aggressive and they were to speak clearly and slowly and when incidents of aggression occurred staff were to complete Antecedents, Behaviour and Consequence (ABC) charts. ABC charts support staff to identify triggers and the most appropriate response from staff when triggers were presented. This care plan was reviewed on 2 January 2017 and staff had recorded that the person's behaviour had become more difficult. The action plan needed to be updated to give staff detailed guidance on how to manage the change of behaviours.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed that there was a lack of activities on the day the day of the inspection. Activities coordinators were employed to support people to follow their interests and to participate in group activities.

On the day of the inspection "No Bake Crispy Bites" was the scheduled activity for 2:30pm. The activities coordinator arrived at 2:40pm following delays and said there was not "enough time left to set up and do the activity now and some people are asleep anyway". Some staff suggested singing but the activities coordinator said that was scheduled for next day and her equipment was at home. The decision was made by staff not to proceed with any alternative activity. The activities coordinator left the room saying drinks would be served at 3pm anyway. We saw staff talked to people on a one to one basis and showed them a musical bird and a puzzle. People did not engage and many were asleep. No activities other than music were offered. This meant people were left for long periods of time with nothing to do.

There was a day board on the wall in the lounge, but the only information displayed was the month of January. There were spaces for the day, date and year, but these had been left blank. The weather display showed the weather to be rain, hot, cloudy and sunny. This meant that inaccurate information such as this may confuse people who were living with dementia.

People told us "I like clues to workout," "I used to knit" and "No there's not enough to do here". After lunch there was loud lively music in the lounge area. We asked people if they liked the music. Some didn't like the music but others were relaxed while enjoying the music.

When asked a relative about activities they said "there seems to be enough to do" and "Mum looks forward to [the Activities Coordinator] coming in, and enjoys the activities", and gave examples such as quizzes, music and hairdressers.

Afternoon activities were advertised on the activity board in the hall outside the lounge, with current activities at eye level and future activities just above. We observed a member of staff adding pictures of the activities to the board. These include 'toss and talk ball games', music and manicures, no bake baking, singalong fun and games, quoits and movie afternoons with popcorn and ice-cream. There were fliers for the movie afternoon and the activity assistant told us this was set up to resemble going to the cinema and that one resident said the week before "I mustn't be late for the picture house".

A member of staff said "there have been improvements made to activity recording" and showed me the old and new paperwork to show that more detail of the activity and what the resident managed to do is recorded by all staff. There is a hairdresser that comes on site, allowing the residents the opportunity to 'go to the hairdressers'. Apparently the hairdresser also sometimes comes into the unit when requested.

A member of staff said "activities are individually tailored to the residents", and gave examples such as particular sensory equipment for certain residents, and talked about one resident who likes an activity that involves winding up wool with her hands with help.

Other care plans reviewed provided staff with the guidance needed to meet people's needs in their preferred manner with the person's ability to manage their care. These care plans were reviewed with relatives where appropriate. Records of visits from relatives were maintained and described the information relayed which ensured they were updated about their relative's current needs.

A member of staff said they had support from the seniors to update care plans. They said "we take our time to ensure the information is included. It's not just a list of things they [people] need. It [care plans] will not meet their needs and must have likes and dislikes. Another member of staff said the care plans gave staff "feedback about people's changes. For example, monitoring weight loss and refer people to dieticians".

A relative we spoke with said they were happy with the level of care their family member living at the service received. They told us, "I think the care people get here is wonderful, I've got no complaints". Another relative said they knew about the complaints procedure and stated "I know the complaints procedure as I have a booklet they gave me, although I have no concerns at all".

Requires Improvement

Is the service well-led?

Our findings

At the comprehensive inspection in May 2016 we found that there was a lack of quality auditing and governance processes. We found the lack of clear quality auditing process had not informed the senior management team including members the board and nominated Individual of the ongoing concerns we identified during the inspection. As a result no actions had been taken to assess, monitor, mitigate risks and improve the quality of the service. Limited action had been taken to address shortfalls identified in previous Care Quality Commission inspection reports and to prevent the reoccurrence of issues. We took enforcement action and imposed conditions on the registration. The provider was told to undertake monthly audits and provide the Care Quality Commission a report which confirmed the dates on which these audits have taken place and states the action taken or to be taken as a result of these audits.

Following the last inspection we have received monthly audits telling us how the service was meeting expected standards, the improvements made and where standards were not fully met the action on how they were to be met. The action plan for the service included the dining experience for people, care planning and the environment. For example, the timescale for care planning was ongoing, care plans were audited and training had taken place on developing the care plans. We found care planning was ongoing and further improvements were needed staffing levels. Since the last inspection there were changes with the nominated individual and the registered manager. Members of the board have become more involved in the running of the home.

Records were not always up to date and accident reports lacked detail. Reports of incidents and accidents were completed by the staff. An incident of physical aggression from a distressed person living with dementia lacked detail on the events surrounding the incident. We found an investigation of an incident had not occurred to where appropriate introduce measures that prevent or minimise any reoccurrences of the same incident. For example, whether staff followed the action plan on managing difficult behaviours, if a review of the risk assessment was to take place and the triggers exhibited that may have led to the behaviour. This incident occurred prior to the current registered manager's appointment. This meant there was a lack of monitoring by the manager that was in day to day management of a service while in special measures.

Risk assessments were not updated on how staff were to support people to prevent them from falling. The care plan dated 1 October 2016, for one person, stated they needed guidance and were able to walk independently. The moving and handling risk assessment stated the person needed minimal support. The falls risk assessment dated 23 January 2017 stated the person was unsteady and at high risk of falls. Records showed this person had experienced a number of falls.

We saw consent to take photographs was gained from a relative. However, lasting power of attorney was not in place for this relative and not within the principles of the MCA. The MCA assessment dated 16 November 2015 for another person stated the person at times resisted assistance with personal care and staff were to provide reassurance. The assessment lacked detail on the best interest decision reached. Action plans were not developed on how staff were to assist the person with their personal care. A member of staff said some

people at times refuse assistance from staff with personal care and they were given time for them to change their decision.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us a monthly log of "slips, trips and falls" was maintained and each incident was discussed with the unit manager. They said the purpose of the discussion was to identify risks to prevent further reoccurrences. It was also stated there were no trends of patterns from the investigation of incidents. Where people were falling frequently referrals were made to falls team.

We discussed the high turnover of staff with the registered manager. The registered manager said some issues with staff culture had resulted in staff being taken down a formal process and some had chosen to leave. We have continued to recruit new staff to the service. This registered manager also said mentoring was to be introduced for new staff. The mentor [experienced staff] was to be matched to the new staff to help them integrate.

Surveys were being used to seek the views of relatives about the quality of service provided. The questionnaires had been sent to gain feedback about the décor, activities and how staff greeted people.

A member of staff said staff meetings had been introduced. The staff meetings were an opportunity for the registered manager to cascaded information to the staff. Another member of staff said team meetings for all staff took place and at the team meetings the registered manager informed staff on the changes needed to make improvements. They stated "[The registered manager] say if we need to talk on a team meeting will be arranged." It was also stated that there was good communication with the unit manager and stated "you don't need to worry. You know you will be supported."

We spoke with a Care Home Liaison link practitioner who told us their visits to the home were weekly. They told us the training to staff had improved and staff were undertaking the Care Certificate with a dementia training module. It was stated that staff were "trying hard to make it a pleasant place to be [for people]. This practitioner also stated that the unit manager was very able and had enabled shadowing opportunities of staff and were more knowledgeable about people.

The registered manager said the "high quality care and high quality environment" was offered and Hillcrest House offered people living within Avonpark a care environment from an independent living accommodation as their needs progressed.

A member of staff told us the staff worked well together. They said the same agency staff work at the home and these staff know the people living at the service. It was stated "we are all on the same page. There is no uncomfortable feeling. It's doesn't feel like work anymore it's like a hobby". Another member of staff told us the team had improved since the appointment of the registered manager. They said the registered manager was approachable and stated they "felt confident to put their views across and [the registered manager] would listen and act upon [their suggestions]. It's a team".

The registered manager said some issues with staff culture had resulted in staff being taken down a formal process and some had chosen to leave. We have continued to recruit new staff to the service.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always person centred. Care plans were duplicated in places and the information was inconsistent with each other in places.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always updated when people's needs changed. There were inconsistencies of information and some reports lacked detail.