Care Quality Commission

Avonpark Village (Care Homes) Limited

Hillcrest House Care Home

Inspection report

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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

Overall summary

We carried out an unannounced inspection of Hillcrest House on the 13 and 15 January 2015. At the last inspection we found there were breaches of legal requirements for Care and Welfare Regulation 9, Cleanliness and Infection control Regulation 12, Staffing Regulation 22 and Records Regulation 20. The provider said they would take action to address the concerns by 13 October 2014. At this inspection we found there had been some improvements but more work was needed to ensure they were meeting the requirements of these regulations

Hillcrest House is a registered location operated by Avonpark Village (Care Homes) Limited. Care is provided to 34 people living with dementia

The manager was not registered with the Care Quality Commission. 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.

People at the home were living with dementia and were not able to express their understanding of safety and how this was to be achieved. Members of staff showed a good understanding of procedures to keep people safe, including their responsibility to report suspected abuse.

Summary of findings

The internal environment was not stimulating for people who liked to walk around the home. Memory boxes on bedroom doors did not have appropriate material for people to identify with their personality or surroundings. People who liked to walk around the property did not have destination points of interest to stop and consider.

People did not have an opportunity to experience a variety regular meaningful activities. Staff told us it was rare for people to go out. The activities coordinator told us the programme of activities was not structured and people preferred to observe and not participate in activities. We saw staff encouraging people to assemble a floor puzzles despite people's specific needs meaning this was an activity they could not complete.

Staff told us they used a person centred approach to care for people. They told us “We care for people as individuals” but we saw there were set routines which meant there was a group approach to care. Care plans did not always include people’s histories, preferred routines and likes and dislikes. Care plans we viewed were varied in quality of detail and did not always provide sufficient guidance on how to meet people’s needs.

We saw staff offer choices to people during mealtimes. Staff told us some people were able to make decisions about their day to day living. However, their capacity to make decisions was not assessed. Staff did not undertake Mental Capacity Act 2005 (MCA) assessments to establish people's capacity. There was no legal framework which governs decision-making on behalf of adults with cognitive impairments such as dementia and who may not be able to make particular decisions. MCA assessments must be undertaken before staff carry out best interests discussions. This meant staff were not fully aware of the decisions people were able to make, the support they needed to make these decisions or who helped them make other more complex decisions.

Staff told us there were staff vacancies and agency staff were used to maintain staffing levels.

Training was provided to develop staff skills to meet people’s changing needs. Senior staff had a one to one meeting with their line manager to discuss their performance and training needs. However, care assistants were not having one to one meetings with their line manager. This meant people may not be receiving care and treatment from staff whose performance and training needs were regularly monitored.

The provider did not check on the quality of the service. Action plans on how to develop and improve the service were not in place. The manager had begun auditing care plans as well as the environment and where standards were not met the action needed was identified.

Codes were needed to gain entry or to exit the building but people living with dementia did not have access to these codes. People on both floors were subject to continuous supervision and lacked the option to leave the home without staff supervision The manager took appropriate actions where there were restrictions in place to keep people safe.

People had access to a GP and were referred to specialist such as Speech and Language therapist and to the mental health team. District nurses who visit the home told us the staff were prompt to seek medical advice and followed this advice.

A relative and health care professionals told us the staff were caring towards people. We saw staff use a variety of approaches which depended on the situation and the person. We saw staff use a gentle approach towards people who were becoming distressed, encourage people to join conversations and offer choices. Staff were respectful but friendly towards people and ensured their rights to privacy and dignity was respected.

Surveys were used to gain relatives feedback about the quality of care and treatment provided to people. Feedback from relatives was considered and action taken for example, a roof terrace was created to give people on the second floor outside space.

Staff told us the manager was approachable and the management style used ensured the staff were supported to fulfil their roles and responsibilities. One member of staff told us the staff were fulfilling their roles and responsibilities and “there were improvements (in the quality of the service)”

We found a breach of Regulation 11. You can see what action we told the provider to take at the back of the full version of the report.

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?

Good

This service was safe.

Recruitment for care assistants and a deputy was in progress and agency staff were used to maintain staffing levels.

The people at Hillcrest were living with dementia were not able to tell us about their experiences of the home. One person said “yes I think I am safe.” The staff had a good understanding of the procedures to keep people safe from abuse and the expectation on them to report poor practice.

We found safe systems of medicine management and infection control.

Is the service effective?

Requires Improvement

This service was not effective.

People received care and support from staff who received the training necessary to meet their changing needs. One to one meetings with line managers to discuss performance and training needs were not happening for all staff. Staff told us appraisals were not taking place annually.

People’s mental capacity was not assessed. This meant the staff were not fully informed of the decisions people were able to make or the support they needed to make them. Staff told us people were able to make some decisions about their meals and their clothing.

People were assisted by the staff to eat their meals where appropriate. We saw staff encourage people to eat their meals and offer them alternatives when they refused meals. We saw snacks and refreshments were offered between meals. Where people were at risk of malnutrition their food and fluid intake was monitored to ensure they maintained a healthy weight.

Is the service caring?

Good

The service was caring.

Outside space was created for people on the second floor.

One person said “yes I like it here.” District nurses who visit the home said the staff were caring and knowledgeable of people’s needs. One relative told us “I think the care people get here is wonderful.”

We saw the staff use a gentle and supporting approach towards people. The approach used by the staff depended on the person and the situation. We saw staff use a calm approach to help people settle and not become distressed.

Is the service responsive?

Requires Improvement

The service was not responsive.

Summary of findings

Staff told us they used a person centred approach to care for people. They told us “We care for people as individuals” but we saw there were set routines which meant there was a group approach to care. Care plans did not always include people’s histories, preferred routines and likes and dislikes. Care plans we viewed were varied in quality of detail and did not always provide sufficient guidance on how to meet people’s needs.

Members of staff told us they attended the training needed to meet people’s changing needs. One to one meetings with a line manager to discuss performance and training needs was not taking place for all staff. Staff told us appraisals were not taking place annually.

One relative told us they had no complaints. Staff told us complaints received were passed to the manager for investigation. A record of complaints received was maintained which included the nature of the complaints and the actions taken to resolve them.

Is the service well-led?

Requires Improvement

The service was not well-led.

A manager registered with the Care Quality Commission was not in post. The manager told us an application to register was to be submitted. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Members of staff told us there had been changes in managers. Staff told us the manager was approachable and improvements were taking place.

The manager told us visits from the provider to assess the quality of the service was not taking place. This meant there was no process for checking standards to then develop a pathway of improvements where desired standards were reached.

The views of relatives was sought about the running of the home. The feedback centred on activities, changes in management and the environment. Action was taken and outside was being created for people on the second floor.

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 carried out by two inspectors. It was unannounced and took place on 13 and 15 January 2015

Before the inspection we spoke to and looked at information from commissioners of the service, previous inspection reports and notifications. Services tell us about important events relating to the care they provide using a notification.

During the inspection we spoke with people, their relatives, the staff on duty, the manager and other visitors including district nurses. We interviewed staff, and 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 observed the interactions between people and staff and we reviewed records.

We looked at the care records of six people, policies and procedures, quality assurance system, schedules and monitoring charts, audits of systems, reports of accidents and incidents and medicine administration records.

Good

Is the service safe?

Our findings

The people at Hillcrest House were living with dementia and were unable express their understanding of safety and how it was to be achieved. One person told us "yes I think I feel safe." During our visit we observed people approaching staff for support and guidance. We saw staff give people time to encourage them and to support them when they were becoming distressed. Staff told us they had attended safeguarding adults training. They were able to explain the types of abuse and the actions they needed to take if they suspected abuse. The agency staff we spoke with told us they had also attended safeguarding adults training.

The manager told us recruitment to cover vacant hours was in progress. Staff told us there were vacancies for caring staff and for a deputy manager. Agency workers were used to maintain staffing levels. A relative told us "there is a lot of agency staff here and that's not good." The staff we spoke with said they were short staffed. One member of staff said "Usually there are only two carers and one senior on this floor (second floor) and we have to do everything. If we had more staff we could do more with them (people)". The rota in place showed a senior was rostered on each floor during the day with two staff on the second floor and one on the top floor.

People were protected from unsafe medicine systems. Medicines were administered by staff who were appropriately trained in safe systems of medicine management. Medicine administration procedures were in place and kept under review. Members of staff who administered medicines showed a good understanding of the procedures and practice for the safe handling and administration of medicines.

Medicines were stored securely. Medicine Administration Record (MAR) charts were signed by the staff to indicate the medicines administered. A record of medicines no longer required was maintained which the contractor signed to indicate their receipt of the medicines for disposal.

Where medicines were administered covertly appropriate steps to gain authorisation had been taken by the staff with lead role in medicine.

People were protected from the spread of infection. We found the home clean and tidy throughout. We saw since the last inspection carpets and furniture had been replaced and one bathroom was converted into a wet room. A housekeeper told us they shared infection control lead roles with another member of staff. We were told training was to be provided and the housekeeper said "but infection control audits had started" to ensure standards of hygiene were maintained which reduced the spread of infection. Cleaning schedules were in place for areas of the home such as bedrooms, bathrooms and toilets. We saw the schedules were not consistently completed by the staff. This meant audits systems were failing because it was not possible to determine that cleaning duties had been carried out.

Risks were assessed and where risks were identified an action plan was devised. For example, the integrity of portable electrical equipment was assessed to set the frequency for testing. Fire risk assessments were developed by an external company. During the inspection we observed the staff put into practice evacuation procedures when the fire alarms were triggered. For example ensuring fire doors were closed. We saw staff were prompt in the action they took and quickly identified a false alarm.

Requires Improvement

Is the service effective?

Our findings

Staff told us the training provided ensured they had the skills to meet people's needs. The activities coordinator told us they were undertaking vocational qualification on providing activities to people living with dementia. This training was to ensure people living with dementia participated in meaningful activities. A senior staff member on duty told us since the last inspection training was more regular for all staff including night staff. This member of staff said this was "encouraging." A training programme was introduced by the manager which included essential training such as dementia awareness, managing difficult behaviours, infection control, Mental Capacity Act 2005 and safeguarding vulnerable adults.

Agency staff told us they had received an introduction to the home. However, the quality of the induction provided to these staff was variable and depended on who gave the induction. One agency worker told us their induction consisted of a tour of the home including the location of fire exits and another said a verbal handover was provided.

Staff told us one to one meetings to discuss their performance and their training needs were not taking place regularly. They told us the manager was approachable. This member of staff said appraisals had not happened in over two years. The manager told us one to one meetings were with the line manager. They told us since their appointment as manager one to one meeting with senior carers had taken place but one to one meetings from senior carers with care assistants were not yet organised.

People were not able to leave the first or second floor as they did not have access to codes for keypads only known to staff and their relatives. This meant people's liberty was restricted. The manager told us Deprivation of Liberty Safeguards (DoLS) applications were in progress for the people living with dementia. The people on both floors were subject to continuous supervision and lacked the option to leave the home without staff supervision. DoL's provide a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

People ability to make decisions was not assessed. MCA assessments provide the legal framework which governs decision-making on behalf of adults with cognitive impairments such as dementia who may not be able to make particular decisions. MCA assessments must be undertaken before staff carry out best interests discussions cognitive impairments such as dementia capacity to make decisions was not assessed. Consent was gained to have their photographs taken and Do not attempt resuscitation in the event of a pulmonary attack (DNACPR) were signed by the GP and relatives where they were involved in people's care. Members of staff were not able to demonstrate a good understanding of the Mental Capacity Act 2005 (MCA). Some staff were not able to explain their role in helping people who lacked capacity to make day to day decisions. A member of staff said they acted in people's best interest but they were not aware they should follow MCA 2005 for people who lacked capacity to make decisions.

This meant staff were not aware of the types of decisions people were able to make, the support people needed to make decisions and who helped them make more difficult decisions. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Menu boards on each floor kept people informed on the day's menu. We saw there was a choice of meals at each mealtime. On the first floor we saw the meals served were not as specified on the menu board which could be confusing for people particularly those with dementia . We saw staff asking people to choose the meals and dessert for the following day.

People were assisted with meals where necessary. We saw people were encouraged to eat their meal and staff offered alternatives when people refused the choice of meals. We saw the senior on duty on the second floor supervised the lunchtime meal to ensure the staff were supporting people to eat their meals. This senior told us they catered for special diets including soft diets.

Where people were at risk of malnutrition their food and fluid intake was monitored. We saw people were offered refreshments and snacks between meals such as biscuits and cakes.

People were registered with a GP who visits the home each week. An emergency nurse practitioner told us their visits

Requires Improvement

Is the service effective?

were weekly to discuss concerns and prevent deterioration of people's health. District Nurses told us the staff were knowledgeable about people's needs. Visits from social and healthcare professionals were recorded and included was the outcome of their visit. We saw people were referred to specialists by their GP. For example Speech and Language Therapists (SALT) for people at risk of choking.

Good

Is the service caring?

Our findings

One person told us “yes I like it here.” Two district nurses told us “I have to say, people are well cared for and staff are knowledgeable about people.” A relative told us “I think the care people get here is wonderful.”

We saw there was a calm atmosphere on both floors. We saw staff use a variety of approaches to encourage people. We saw for some people the staff used a friendly approach and offered guidance to people who wanted to find their way around the home.

We saw staff spend time in the lounge helping people with their activities such as crossword. Staff spent time talking to people and when people became distressed the staff offered reassurance to help the person keep calm.

Staff were knowledgeable about people's needs and their communication abilities and their preferences.

Staff gave us examples on how people’s rights were respected. We saw staff use a discreet manner when they approached people who required personal care support.

Requires Improvement

Is the service responsive?

Our findings

People did not have access to a variety of meaningful and appropriate activities, there was no choice of activity and they did not occur on a daily basis. A member of staff on the first floor told us "I've been here three and a half years and I've never known them (people) to be taken on an outing or anything. Sometimes one or two (people) might get taken for a walk around the garden but it's always the same people and I haven't seen them go out for ages." We saw recorded in care plans that people were at risk of social isolation and the outcome was to "provide a variety of suitable social interaction." The activities coordinator told us relatives were asked to provide background information about people's interests and where possible this activity was provided. It was explained there was no specific programme of activities because people were not "keen to have structured activities." We were told the activities such arts and crafts were organised for small groups but people did not participate but were more likely to observe the activity. We were told poetry and short story reading were other activities organised and following the readings the subject topics were discussed. We saw on the first floor lounge a floor puzzle being assembled and staff were encouraging people to participate. This activity was not appropriate as it was difficult for older people to assemble a floor puzzle.

Adaptations were taking place to give people on the second floor access to outside space. A roof terrace on the second floor was being created. The internal building was not stimulating to people who liked to walk around the property. We saw people walking around the property but memory points, fiddle boxes or points of interest for people to stop and consider were not available. Memory boxes outside people's bedrooms used to help them express their interest and to recognise their surrounding did not contain appropriate material. The internal environment did not have destinations that were of interest or helped people find their way around the property.

Staff said "we care for people as individuals. We give people one to one time we sit with them." We saw the staff use a kind and attentive manner towards people but the delivery of care was in a group approach. A member of staff told us some regimes such as meal and snack times were at set times. Not all the care plans we viewed had people's personal histories, their preferences and routines. A summary of care was in place for some people which described the support needed from the staff. This meant people's preferred routines were not taken into account.

Staff told us care plans were devised by senior carers. Relatives told us they were not invited to care plan reviews. One relative said "What is a care plan. I've never seen XX care plan." We saw staff had recorded in the care plans when consultation about people's needs had taken place.

People's level of dependency was assessed which included the potential of people developing pressure sores and malnutrition. The care plans developed from the assessments were variable in detail. Care plans did not give staff direction on how to meet the person's need.

Staff told us there were people who used aggressive and violent behaviour to communicate. We were told some people became aggressive when they were in pain. Care plans to manage difficult behaviour did not give detailed guidance on the diversion or distraction techniques to use. This meant the staff did not have access to information that would assist them to correctly manage aggressive or violent situations.

Staff told us when complaints were made they were passed to the manager for investigation. A relative we spoke with said "I've no complaints." A log of complaints was maintained which showed the nature and the actions taken to resolve the complaint.

Requires Improvement

Is the service well-led?

Our findings

A manager registered with the Care Quality Commission was not in post. The manager told us an application to register was to be submitted. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff told us there had been changes of managers in the last 12 months. One member of staff said "there is a lot of improvement. For example, dishwashers were removed [which reduced the tasks care staff had to undertake after meals]. The manager checks on the staff." We were told the current management style was supportive which ensure staff were fulfilling their roles and responsibilities.

Staff told us the culture of the home ensured they were able to challenge staff practice and where there were concerns they felt confident to report poor practice.

The views of relatives about the quality of the service were sought using surveys. Three responses from relatives were received and their feedback was based on activities, changes in management and working environment. We saw their comments and suggestions were taken seriously because an outside space was being created for people.

The manager told us the provider did not check on the quality of the service. We saw an audit of care plans were in progress. We saw where care plans were not correctly completed an action plan with timescales was devised. Accidents and incidents were assessed to identify trends and patterns. We looked at the records of accidents for both floors and in December 2014 there had been 13 accidents. The manager said the heads of units were responsible for ensuring action was taken to prevent further reoccurrence. We saw accident form included the actions to be taken to prevent any reoccurrences.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People's capacity to make decisions was not assessed to determine the decisions they were able to make and who helped them with more complex decisions.**