Avonpark Village (Care Homes) Limited

Hillcrest House Care Home

Inspection report

Avonpark
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Bath
Avon
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 18, 19 and 23 May 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of Regulation 12 and 13.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hillcrest House on our website at www.cqc.org.uk

At this inspection we found the provider had taken action to address the issues highlighted in the warning notices. The provider had developed a comprehensive action plan to address the warning notices and other requirements in the inspection report where they were found to be in breach of regulations. We could not improve the existing inadequate rating because to do so requires a comprehensive inspection.

Hillcrest House can provide accommodation and personal care up to 34 people living with dementia. At the time of our visit there were 11 people accommodated

A registered manager was not in post. A unit manager was in post to provide day to day management presence. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider. 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 were not able to tell us about their experiences of living at the home. We saw staff sitting with people and there was good interaction between them. People were assisted by the staff and their behaviour showed the intervention from staff was welcomed. We saw staff supporting people to make decisions for example choosing meals. All assistance offered by staff was accepted.

Members of staff said that they had refresher training to ensure people were safe. The staff we spoke with knew the types of abuse and the actions they most take for alleged abuse. For example they knew where there was physical abuse by one person towards another this had to be reported.

The whistleblowing procedure, including the contact details of agencies staff were able to raise their concerns with, was on display in the office. This included the organisation's commitment to improve standards of care to people. Members of staff knew it was their duty to report any poor practice they may witness. They told us they would not hesitate to report alleged abuse to the line manager.

Risks had been assessed and associated risk assessments had been developed. Members of staff described the actions they must take reduce the risks to people. Risk assessments were in place for moving and

handling, for people at risk of pressure damage and for people who may at times exhibit challenging behaviour.

We spoke with an external healthcare professional who said the service had improved since our previous inspection. Two staff said there had been improvements in the quality of care and were confident the improvements would be sustained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had been taken to improve safety.

Staff knew the actions needed to minimise any risks identified and risk assessments were developed on how to minimise risks

The members of staff we asked were able to tell us the safeguarding of vulnerable from abuse procedures including the types of abuse. These staff felt confident to report their suspicions of abuse.

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.'

We undertook an unannounced focused inspection at Hillcrest House Care Home on 25 August 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection date 18, 19 and 23 May 2016 inspection had been made. The team inspected the service against one of the five questions we ask about services: Is the service Safe. This is because the service was not meeting some legal requirements.

The inspection was undertaken by an inspector and an inspector manager. During our inspection we spoke with the unit manager, two senior carers and one care assistant. We also spoke with a healthcare professional. 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 spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Inadequate

Is the service safe?

Our findings

We identified breaches of regulations at the previous inspection which took place on 18, 19 and 23 May 2016. We found that where staff had raised concerns or used the whistleblowing procedures about incidents and accidents these were not taken seriously and acted upon. Processes were not operating effectively to prevent potential abuse to people. In addition the staff were not always recognising the signs of abuse and taking appropriate action to prevent abuse from occurring.
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 who had fallen was not available.

We found improvements had been made in relation to safeguarding of vulnerable adults and risk management.

The people living at Hillcrest were not able to tell us about their experiences of living at the service. We saw people were comfortable in the presence of the staff. We saw people discussing events with staff and smiled as they approached. We observed a member of staff assisting one person to sit at the table and this member of staff introduced the person to the other people sitting at the table. At lunchtime we saw the staff asking people to make a choice from the options shown. Where people's preferences were different from the options shown the staff offered people an alternative.

Staff were aware of the safeguarding of vulnerable adults from abuse policy and procedure. A member of staff said they were registered on the Care Certificate course to ensure they had the skills needed to keep people safe. The unit manager told us safeguarding referrals were made for allegations of abuse which included incidents of alleged physical abuse between people. They told us better working partnerships were developed with lead agencies. For example, for people with bruising the lead authority for safeguarding were contacted to discuss the nature of the incident and the actions to take. A member of staff explained a recent incident where one person hit another and a safeguarding referral was made as well as seeking input from the mental health team and the GP to prevent further reoccurrences.

We saw the Whistleblowing procedures were on display. Within the procedure the organisation's commitment to achieving high standards of care were described. Staff were encouraged to come forward and report their allegations of abuse and were able to raise their concerns anonymously. The contact details of the organisation, local authority lead in safeguarding and CQC were included for staff to contact with their concerns. A member of staff told us the unit manager would be made aware of their concerns about other staff. Another member of staff said if they were to observe poor practice by other staff they would not "hesitate" to report their concerns. The unit manager told us they led the team in an open and honest manner. They told us at regular one to one sessions with the staff, concerns were discussed and where there were allegations of abuse safeguarding referrals were made.

Where risks were identified assessments were devised on minimising the level of risk to the person. We found assessments for people at risk of falls, for people at risk of developing pressure ulcers and for people

that may resist personal care.

The Moving and handling risk assessment dated 11 June2016 for one person gave staff guidance on how staff were to assist this person with transferring from bed to wheelchair. The type of equipment to be used and the number of staff needed was included in the risk assessment.

The risk assessment for one person identified a high risk of developing pressure ulcers gave staff directions on minimising the risk. Members of staff were to reposition the person two to three hourly and to ensure improvements with skin integrity they were to follow continence regimes which were also described in the care plans.

The personal care plan for one person resistive to care described the person's usual behaviour and the number of staff required to support the person during these periods. Where the person became resistive to personal care the staff were to calmly explain the procedure and they were to return after giving the person time to become calm.

The unit manager told us members of staff report any injuries sustained by people. There was an expectation that staff completed incident forms which include the cause of the injury if witnessed. Body maps that show the location of the injury were in place and discussed at every handover until the injury had healed. Accident forms in place gave a description of the accident, the actions taken, the agencies informed and a post incident plans were included.

Members of staff were informed of people's current needs when they arrived on duty. Handover sheets gave information on people's current needs. For example, injuries, referrals to external agencies such as Speech and Language Therapists (SaLT) for people with poor appetite and repositioning of people.

We spoke with a healthcare professional who said the unit manager was "on the ball" and that, documentation had improved. There is structure and a methodology. More leadership and direction. They are in a much better place." A member of staff said staffing levels had improved a unit manager was appointed and there was less pressure on the "seniors". They said one to one meetings were taking place and training was organised. Another member of staff said there had been a lack of trust with previous senior managers. They said previously improvements were made but not sustained and staff left. This member of staff was hopeful these improvements would be built on.