Four Seasons (DFK) Limited

# Hilltop Manor Care Home

## Inspection report

High Lane
Chell
Stoke On Trent
Staffordshire
ST6 6JN

Tel: 01782828480
Website: www.fshc.co.uk

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09 February 2018

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 18, 19 January and 9 February 2018 and was unannounced.

At the last inspection the service was rated Requires Improvement. At this inspection we found that the service had deteriorated and more improvements were needed. We identified some Regulatory breaches and we told the provider that improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service has a rating of 'requires improvement' overall but was rated 'inadequate' in well led.

Hilltop Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hilltop Manor Care Home accommodates up to 80 people in one adapted building and care is provided over two floors. Each floor has its own unit manager and separate adapted facilities. At the start of this inspection there were 62 people using the service.

There was a registered manager but they were not working during this inspection and they have since left the provider's employment. 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. There was an acting home manager in place with additional support from the provider.

People's risks were not always safely managed. The systems in place to monitor safety and quality of services provided were not always effective in identifying issues and implementing timely changes.

People were not always protected from avoidable harm as potential safeguarding incidents had not always been investigated, reported or action taken to reduce the likelihood of them reoccurring.

Systems were not effective in identifying concerns and resolving them in timely manner which left people at risk to their health and wellbeing.

People told us they received their medicines when they needed them but we found that improvements were needed to the way medicines were managed to ensure they were safe.

We found that staff sometimes spoke about people in an undignified way, which sometimes compromised their privacy and dignity.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service support this practice. However, staff needed more support to understand the relevant law in relation to this.

People had access to healthcare professionals when they needed them; however improvements were needed to the handover systems to ensure that important information was passed over within staff teams and to professionals.

Some people's care plans did not contain up to date and relevant information that staff needed in order to provide personalised care, including information about their wishes for end of life care. The provider had a plan in place to address this.

There were enough safely recruited staff to meet people's needs and people were protected from the spread of infection. Staff were provided with training and support in order to provide effective care, however staff felt they would benefit from more face to face training and guidance to improve their understanding in some areas.

People mostly, but not always, had choices about their care and treatment and enjoyed the food on offer. People were happy with the care they received and felt that staff treated them in a kind and caring way. They told us they had access to activities they enjoyed.

People felt comfortable to complain if they needed to and the provider had a suitable complaints policy in place. People were provided with the opportunity to give feedback about their care and this was acted upon.

## 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 risks were not always safely managed.

People were not always protected from avoidable harm.

Medicines including prescribed creams were not always safely managed to ensure that people always received them as they were prescribed.

There were enough safely recruited staff to meet people's needs and people felt safe. People were suitably protected from the risk of infection.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People's consent to care was sought and decisions were made in their best interests when required, in line with law and guidance. However, staff needed more support to ensure they understood the law in relation to this.

Staff were provided with training and were beginning to feel more supported in their roles. The home was suitably adapted to meet people's needs but could be more dementia friendly.

People generally had access to healthcare professionals when required but handover sessions in the home weren't always effective in ensuring relevant information was passed on.

Improvements were needed to ensure people's assessments were up to date and that they received effective support to eat.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

We heard staff using undignified language when talking about people they support and we heard staff talking about people's personal care in communal areas which did not respect their

privacy and dignity.

People mostly, but not always, had choices about their care and treatment.

People told us they were happy with the care they received and that staff treated with kindness and compassion and promoted their independence.

## Is the service responsive?

**Requires Improvement** 

The service was not consistently responsive.

Some people's care plans needed to be reviewed and updated to ensure that staff had the information they needed to provider personalised care. The provider had plans in place to address this.

People's wishes in relation to care at the end of their life was not consistently recorded, though plans were in place to ensure people had access to medicines and healthcare professional to ensure they were comfortable at the end of their life.

People had access to activities they enjoyed.

People felt comfortable to complain if they needed to and there was a suitable complaints policy in place and displayed within the home.

## Is the service well-led?

**Inadequate** 

The service was not well-led.

The provider had not ensured that required improvements were made and sustained following the last inspection and we found the service to have deteriorated.

Systems in place to improve safety and quality had not been effective in identifying issues and implementing timely improvements.

The provider had an action plan in place to make improvements and were working with other organisation to help achieve effective outcomes people. People and staff felt included in the development of the service and an open and positive culture was developing.

# Hilltop Manor 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.

The inspection was prompted in part by information we had received from the local authority commissioners and safeguarding adult's team. It was also prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. CQC was aware of past concerns that were being investigated and this prompted us to bring our planned inspection forward to look at current care delivery and the provider's response to the local authority's concerns.

This inspection took place on 18, 19 January and 9 February 2018 and was unannounced. The inspection team consisted of three inspectors, a specialist advisor with expertise in nursing care for older people and an expert-by-experience, who is a person who has personal experience of using or caring for someone who uses this type of care service.

We used the information we held about the service to formulate our inspection plan. This included statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. These include information about safeguarding concerns, serious injuries and deaths that had occurred at the service. We also considered feedback received from the local authority commissioners, safeguarding adults team and the local clinical commissioning group about the services provided at Hilltop Manor Care Home.

We spoke with 12 people who used the service and nine visiting relatives. We did this to gain people's views about the care and to check that standards of care were being met. 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 21 members of staff including four nurses, two activities coordinators, three care home assistant practitioners, a kitchen assistant, a maintenance assistant, two unit managers and the deputy manager. We also spoke with a visiting healthcare professional. We observed how

care staff interacted with people in communal areas and looked at 24 people's care records. We spoke with the acting home manager and the acting regional manager along with a member of the provider's project team who were supporting the home to make improvements.

We also looked at records relating to the management of the service. These included five staff files, training records, meeting minutes, an action plan and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection we found that improvements were needed to ensure that people received safe care. At this inspection we found that further improvements were still needed and a breach of Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

We found that people's risks were assessed, however these risks were not always safely monitored and managed to ensure people's safety. One person was admitted to the home with a history of falls and was assessed as being at high risk of falls on their admission to the home. No measures were put in place to reduce their risk of falls. The person fell whilst they were unsupervised in their bedroom and fractured their wrist three days after admission to the home. This showed that a risk had been identified, actions had not been taken to reduce the risk and the person suffered harm as a result of this. Following this fall, their risk assessment was updated to include observations of the person every 30 minutes to try and reduce their falls risk. However, we found no records of these observations and staff confirmed that these observations were not being carried out. We observed that the person sat in the lounge and was supervised by care staff who were receiving their induction and were not familiar with the person's needs and risks. This meant that risks were not managed to ensure people received safe care. We have asked the provider for further information about this specific incident.

Another person had a behaviour care plan in place which stated they attempted to climb over their bedrails when they were anxious. This increased the person's risk of injury if they were to fall when climbing the bedrails. When the fitting of these bedrails had been decided upon, there was no evidence that the increased risk to the person of attempting to climb the rails had been considered. There was no evidence that other options had been considered to lower the risk of falls from bed. This meant the person was at risk as insufficient consideration had been given to other options and we could not be sure effective action had been taken to reduce the risk of climbing the bedrails and protect the person.

People had risk assessments and management plans in place. However, we found that these were not always followed. Some people slept on an airflow mattresses. An airflow mattress helps people to maintain skin integrity by relieving pressure and the mattresses have different settings according to people's size. Plans were in place to state what setting each mattress should be on for different people. Staff were recording that they were checking the mattress settings, however they had not identified some of the settings they were checking were different to the one recorded in people's plan. This meant there was a risk to the person's skin conditions worsening or not healing which posed a risk to the person's health and wellbeing.

One person usually slept on an airflow mattress. However, they were sleeping on a normal mattress due to a fault with their airflow mattress. Staff told us and had recorded that the person needed to be turned regularly to ensure they didn't develop any pressure sores whilst on the normal mattress. However records showed this was not always happening. It was also unclear whether the person already had a pressure sore or not. Care plans and wound plans still made reference to the person needing support with a pressure sore. The unit manager told us the sore had healed. However plans had not been recently reviewed to reflect the

person's change in need so we could not be sure they were being supported appropriately. The person also needed creams applied to their skin to reduce the risk of their skin deteriorating. The Topical Medicine Administration Records (TMARS) where staff record creams as being applied had multiple days where nothing had been recorded. Therefore we could not be assured that the person was being supported appropriately to maintain their skin integrity and they were at risk of further skin damage as guidance for staff was not always available and guidance that was present was not always being followed. This left the person's health and wellbeing at risk. Another person was assessed at very high risk of developing pressure sores. Part of the risk management plan to reduce the risk of sores developing was that the person should be supported to change their position every two hours as they were unable to do this themselves. Records showed that their position changes were regularly three and four hours apart which meant that risk management plans were not consistently being followed and the person had pressure damage to their skin.

Insufficient action had been taken in relation to people losing weight. Unintentional weight loss can indicate if someone is unwell. People's weights were not always rechecked when required to ensure the measurements were correct and referrals to other health professionals were not always evident. The regional manager and acting manager told us that usually a loss of 2.5kg would trigger additional action to be taken to try to reduce the likelihood of a person losing any more weight. However some people had been recorded as losing more than this amount and no action was evident. This meant people who had lost weight were not always being supported in a timely way which could put their health and wellbeing at risk.

Some people spent time in their rooms and had a call bell to alert staff when they needed assistance. However we observed that call bells were not always within people's reach. We heard one person shouting for the nurse because they were short of breath and needed their inhaler. Although the person was usually able to walk with the assistance of a frame, on this occasion they were not able to because of the shortness of the breath and their call bell was not left within their reach. The inspector alerted staff to this person's needs for support. This meant that people were not consistently supported to stay safe.

The above evidence shows that care and treatment was not always provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not consistently protected from avoidable harm. We found that unexplained bruising had not always been investigated or reported as a safeguarding concern. All safeguarding concerns should be reported to the local safeguarding authority. We observed that one person had obvious bruising to their face. We looked at their daily records and saw that the bruising had been recorded by care staff two days prior to the inspection but no further action had been taken to seek medical attention or safeguard the person from further injury. Staff had recorded they had completed a body map of the bruising but we could not locate this. The following day another member of care staff had recorded that they noticed the bruising, they completed a body map which we saw and informed the nurse in charge. The cause of the bruising was not recorded. We spoke with the deputy manager who was unaware of the bruising despite it being recorded on the clinical handover report the previous day. The nurse in charge had made an assessment about the cause of the bruising and felt they knew how it was caused and that there was no need to report the concern to the local authority under safeguarding adult's procedures. However, there were no records that showed this concern had been considered and the rationale for not reporting under safeguarding adults procedures had not been recorded. The deputy manager agreed this should have been reported to safeguarding and did this following our conversation with them.

During our visit on 9 February 2018 a body map folder was in place so that when a body map had been completed by a member of staff, it would be put into this folder. We observed one person had a large bruise to their wrist. A body map had been completed and was in the body map folder. When we checked with a

member of staff they confirmed no action had been taken and no action had been recorded. The same member of staff was unable to tell us what action should have been taken, such as investigating the cause, reporting to managers or reporting it to the local safeguarding authority. Another body map was present which recorded bruising to a person's arms and there was no evidence of action taken. This meant the service could not be sure how this injury had occurred as no action to investigate had taken place, it had not been reported to the local safeguarding authority and no plans were put into place to reduce the risk of a similar injuries occurring again. This meant people were not always being protected from avoidable harm.

The above evidence shows there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, some improvements were required to ensure that people's medicines were managed safely. People told us and our observations confirmed that people got their regular prescribed medicines when they needed them. One person said, "I get my medicines on time and staff always ask if I need anything for pain." We saw that staff administering medicines took time to sit down with people to ensure that people could take their medicines in an unrushed and safe way. Some people were prescribed 'as required' medicines such as pain relief or anti-anxiety medicines. Some of those people had protocols in place which guided staff on how and when to administer these. However we found that some people did not have these clear plans in place. For example one person was prescribed medicines 'as required' for agitation. However the plan did not clearly describe to staff how the person displayed agitation and at what point the medicines were required. Staff confirmed that the person was new to that particular area of the home and they were still getting to know the know the person, so this meant there was risk that they may not consistently receive their medicines as it was required and prescribed. We spoke with the regional manager who immediately arranged for the protocol to be amended and updated and we saw this was completed to a suitable standard on the second day of our inspection. There were plans in place for all people's 'as required' plans to be reviewed.

We found that the system for recording when prescribed creams had been applied needed some improvement. There were gaps in records which meant we could not be assured that people had received their creams as they had been prescribed. The provider had identified there was a need for improvement in this area and had recently introduced a separate trolley for creams and a separate recording system. However we found there were still inconsistencies in the way staff were recording the application of creams and some staff were unclear about their responsibilities and systems in place so this needed improvement to ensure creams were consistently applied as prescribed.

At our last inspection we found that improvements were needed to ensure that people were supported to move safely because people who required support to move using a hoist were being supported to move using a different sized sling from the one the person had been assessed for. The use of the incorrect sized sling could make the manoeuvre uncomfortable or unsafe for the person. We also saw that people were not provided with individual slings which could expose people to the risk of cross infection. At this inspection people told us they were comfortable when staff supported them to move. One person said, "Yes I feel safe and comfortable when being moved. Sometimes I need a hoist to move. There is always two staff so I feel very safe." We found the required improvement in this area had been made and people all had their own individual sling that was suitably assessed. We observed that people were supported to move safely.

People told us there was usually enough staff to keep them safe and meet their needs. One person said, "If I press the buzzer, they [staff] come pretty quickly but I do occasionally have to wait, it can be up to ten minutes but this is rare." A relative said, "I think there is usually enough staff on duty. [My relative] never seems to have to wait long for anything. Its five or ten minutes at the most as they need two staff to transfer

and staff may have to go and find a second person but normally the wait is a lot less." We observed in the morning that people did not have to wait for support and people's requests for support were responded to promptly and anticipated by staff when required. However, in the afternoon, we saw that lounges were unsupervised at times or supervised solely by staff who were completing their induction and therefore did not know people's needs and risks and had not completed all of their necessary training. We heard one person say, "We haven't had a cup of tea or anything for ages, no-one has even asked how we are!" A staff member then came into the lounge and offered that person a drink and other people started to ask for one too. A tea trolley then came round and all people were offered drinks. This showed that people sometimes had to wait for the support they needed in the afternoon. We shared this feedback with the regional manager who said they would look into how staff were deployed in the afternoons.

Staff told us that staffing levels had recently improved. One staff member said, "On occasions there had not been enough staff. In the last few months we have had agency staff which has helped massively." Another said, "There often wasn't the staffing numbers there should be but in the last month there had been a lot of agency staff and I know recruitment is happening so it's getting better." The regional manager confirmed to us that the home had previously been understaffed. They showed us how they used a dependency tool to help work out the number of staff needed to keep people safe and meet their needs. We checked rotas which confirmed the staffing numbers directed by the dependency tool were in place. We saw that recruitment was taking place and a number of staff were in the process of completing induction training and that agency staff had been block booked to cover any shortfalls until all new staff were fully inducted into their roles. This showed that the provider had plans in place to ensure that there were enough suitable staff to support people.

People received support from safely recruited staff. Staff confirmed that recruitment checks were completed to ensure they were suitable to work with people. We saw staff provided two references. The provider checked to ensure staff were safe to work with vulnerable people through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions. This meant safe recruitment procedures were being followed in relation to the employment of new staff.

People told us they felt safe at Hilltop Manor Care Home. Comments included, "I feel safe here because the environment rarely changes. I know that there is always someone around that I can trust should I need them but I still feel that I am in control of things", "I have not been here long but I feel safe because the staff seem quite good and will offer to help me if am struggling with anything" and "I feel safe as staff know what they are doing on the whole and there is always someone available 24/7 if I need assistance. I've got all my own things round me and it is very secure here."

People and their relatives told us that the service was generally clean and tidy. We observed that all areas of the home and equipment looked clean and hygienic and saw domestic staff carrying out their duties throughout the inspection. Staff understood the importance of infection control, and we observed them using protective clothing that was readily available to them and regularly washing their hands. The acting manager told us an infection control audit was competed more often that the provider's policy on infection control stated and they took a lead role in ensuring infection control standards were met. This meant people were protected from the risk of infection and cross contamination.

We saw that the provider had an action plan in place to address concerns that had been raised about the quality of care provided at the service. Concerns had been raised by the local authority and local clinical commissioning group and the provider had recognised these issues and put plans in place to make improvements. We raised our immediate concerns at the end of the inspection with the provider and they provided us with an updated action plan and details of how people would be protected and actions they

would take immediately. This meant that lessons were being learned and improvements were in the process of being made.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection we found that improvements were needed to ensure that people's mental capacity was consistently assessed as required, that decisions were made in people's best interests when required and to ensure that people were not unlawfully deprived of their liberty. At this inspection we found that improvements had been made in this area though improvements were still required to ensure the service was consistently effective.

People's consent to care was sought in line with legislation and guidance. One person said, "Staff always ask me about things before they do anything." 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. We observed that people were asked for their consent before care was carried out. When people lacked mental capacity about certain aspects of their care, we saw that a decision specific test of their capacity was carried out, in line with the MCA. We saw that decisions were made in people's best interests when required in relation to the use of bed rails and being nursed in bed as well as other key decisions about people's care and support. These decisions were well documented and shared with staff to ensure that people's rights were protected.

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 found that people had been referred for a DoLS authorisation when this was required. 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 found that staff were not always aware when people had a DoLS authorisation in place and staff did not fully understand the requirements of the MCA. Although the service were working in line with the current legislation and guidance to ensure that people's rights were protected, care staff needed more support to understand the MCA and what this meant for people who use the service.

Staff were provided were training, however improvements were needed to ensure that staff had the knowledge and understanding to deliver effective care. Most staff were able to identify and describe the action they would take in relation to potential safeguarding incidents however some staff were not able to do this. This left people at risk of not being protected by some staff as they did not fully understand their responsibilities. Staff told us they had received training, however much of it was online training and some felt that they would benefit from face to face training in subjects including dementia care and end of life care. We found that staff knowledge was lacking in relation to the MCA and care staff confirmed that training was online and their competency and understanding had not been checked following completion of the online modules. We did see that simple information about the MCA was displayed around the home for staff to refer to; however, further support was needed for staff in this area of their knowledge.

Staff were beginning to feel more supported in their roles. They told us and records confirmed they received

supervision which was useful to them. One staff member said, "Supervision has been helpful, we talk about how I can improve and my progress so far." Another staff member said, "We get feedback in supervision every few months, you can ask for any support you need." Records showed that supervision was being planned in advance for staff to ensure they felt supported and the acting manager told us that additional training had been sourced and planned for staff to improve their knowledge and skills.

Some people's needs and choices had been holistically assessed; however improvements were needed to some people assessments. The provider was aware of this and a 'tracker' had been implemented to ensure that all people's assessments were updated to ensure they were accurate. Where people's assessments had already been updated, we saw that they were detailed and mostly provided guidance for staff on how to meet the person's needs and choices. However we saw that some care plans were out of date and did not clearly include up to date information on how people wanted and needed to be supported. The provider had plans in place to address this.

People told us they mostly enjoyed the food and were offered choices and alternatives. One person said, "The food is acceptable and you are offered a choice." Another person said, "There is nothing wrong with the food here in general. They come and ask you what you want and if I don't fancy it they do a good jacket potato and cheese here which I really enjoy." When people needed support to eat we saw that this was provided however some improvements were needed to ensure this support was always effective. For example, one person needed a plate guard to help them to eat. A plate guard is a piece of equipment which helps a person to eat independently and stops food from falling from the plate. We saw that a staff member put a person's meal in front of them with a plate guard attached but did not speak to the person or ensure they were happy and comfortable with it. We saw they struggled to eat their meal as the plate guard was in the wrong position for them. Another staff member later noticed and adjusted the position of the plate and the person was able to eat their meal independently. We saw that people's requests for alternatives were catered for and people were happy with this. When people required specialist diets or drinks, we saw these were supplied. For example, some people required thickener in their drinks to help them swallow safely and each person had their own individually labelled thickener with clear instructions that staff followed. This meant that some improvements were needed to ensure that people consistently received effective support to eat.

We found that some improvements were needed to the design of the service to meet people's diverse needs and promote independence. For example, people living with dementia can become confused and unable to differentiate between walls and doors and contrasting colours can help people maintain their independence. We did not see the use of colour, signage or other stimulation at the home. We saw one person who had dementia struggling to differentiate between a white table cloth, white napkin and white plate at lunch time. We fed this back to the acting manager who told us they would arrange for the provider's dementia specialist to look at the environment to help make improvements as there were now more people with dementia living at the home. However, people did have access to some adaptations to help meet their needs such as specialist bathrooms to enable to safely have their personal care needs met. People had access to large lounges and dining rooms where they could choose to spend time together or small lounges with televisions where they could spend time alone, in smaller groups or with their visitors, as well as free access to their own bedrooms. We saw that people were able to decorate their private rooms with their personal items.

Staff told us that they attended a handover session at the beginning of each shift, which helped ensure they had the information they needed to deliver effective care to people. However, improvements were needed to ensure information was passed over because we saw that information relating to bruising on a person's face was recorded on the clinical handover record, but the deputy manager was unaware of this when we

spoke with them and action had not been taken to ensure they were seen by a medical professional. We saw the doctor was present during our inspection and asked the nurse on duty if anyone needed to be seen but he was not asked to see the person who had bruising so the handover session had not been effective in ensuring that all necessary information had been passed on. Other information was also not passed on, such as a person being moved rooms temporarily due to a fault with their mattress and needing to be repositioned frequently and a person having their catheter removed. This meant there was a risk people may not receive care consistent with their current needs.

Despite the examples above, people told us and records confirmed that they were able to see health professionals when they needed to. One person said, "If I am unwell they get the doctor out to see me. This is never a problem." A relative said, "They have got the doctor out whenever [my relative] has not been well and have always kept me informed. Staff phoned to say they were sending for the doctor and then again with the outcome. [My relative] is diabetic and they have arranged for the chiropodist to call and also taken [my relative] to the eye clinic for check-ups." We saw that a weekly multi-disciplinary meeting was held to discuss people's healthcare needs and ensure they received the correct advice and support. A visiting doctor told us, "Staff here always contact us when needed and professional advice is followed. Whenever we tell them to do something they do it, I've never had any concerns." Records showed that referrals were made for some professional assessment and advice when needed and people had access to professionals including dieticians, speech and language therapists, physiotherapists and tissue viability nurses. However, we saw timely referrals if people had lost weight had not always been actioned. This meant that people felt able to access health professionals to maintain their health and wellbeing but more timely referrals were sometimes needed.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection, we found that the service was caring. At this inspection, we found that improvements were required to ensure people received a consistently caring service.

We observed that staff interacted with people in a kind and dignified way. However, we heard staff using undignified language when talking to other staff about people they were supporting. For example, we heard a staff member tell another, "I've got to do the feeders now" when referring to people who needed support to eat. This was not a dignified or respectful way to refer to people. We also heard staff talking to each other about people's personal care in communal areas. For example, we heard a staff member say, "I'm going to change [Person's name]'s pad now." This did not respect the person's privacy or dignity.

We saw that people mostly had choices about how their care was delivered. However, we observed that people all wore aprons at lunchtime and whilst staff were doing this to try and protect people's clothing and dignity, some people did not have a choice in this and we saw that staff put aprons on people without asking, or told them they were going to do it rather than asking them. People told us and we saw they had choices about how they spent their days, what they wanted to wear and what and where they chose to eat. One person said, "I get up when I am ready and go to bed when I like. Staff ask me what I want to wear each day and will get my clothes out for me. As I stay in my room I often choose to wear pyjamas as they are comfy." We saw that staff were aware of particular communication needs that people had and ensured they were able to make choices by communicating in the best way to suit the person. A relative said, "[My relative] is deaf but staff always check to make sure they have heard and understood what they are asking or saying." We found that a residents and relatives meeting was held where changes were communicated to people and they could feedback about the care they received. Copies of minutes were available in large print to ensure people had access to information. This showed that mostly, people were supported to express their views and had choices about their care.

People told us they were happy with the care they received and that staff treated them with kindness and respect. Comments included, "I don't think the care we get could be improved very much. All the staff treat you well. You usually get a cheerful remark which is half the battle for the day", "Staff are very caring and treat you well" and "Staff are very caring and help you if needed. I'm happy to talk to them about things and they will put things right if they can and most will have a laugh and a joke with you." We saw examples of kind and compassionate care delivered by staff. For example, one person's communication was limited and we saw they took the hand of a staff member and kissed it. The staff member returned an affectionate gesture by kissing the person's hand and blowing them a kiss. The staff member said, "[Person's name] likes a little affection. We know that. Although [Person's name] can't talk too well they love a chat and doesn't like the curtains opened." This showed kindness and compassionate and that staff knew people well and delivered support in the way they liked.

People told us their privacy and dignity was respected. One person said, "They do respect your privacy and dignity. Everyone always knocks and asks permission to come in even though my door is usually open." Another person told us, "They all knock on the door every time and close the door when helping me or

talking about anything personal. Also I have a bowel problem and I occasionally cannot make the toilet. I found this really upsetting but the staff are lovely with me if this happens. They tell me not to worry 'its fine we'll get you all cleaned up- no problem.' They put me at ease about it so I am no longer embarrassed and this means that I don't lose my dignity." Our observations supported what people told us and staff were able to tell us about and give examples of how they protected people's privacy and dignity.

People told us their independence was promoted. One person said, "I do things for myself mostly but care staff notice if you are not good and always offer support." Another person told us, "I'm having physiotherapy and can walk with a Zimmer frame and a few steps independently. Carers all encourage me to do what I can for myself and are quite content to let me get on in my own way most of the time if it's safe although they always ask if I need help."

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection, we found that the service was responsive. At this inspection, we found that improvements were required to ensure people received a consistently responsive service.

We found that people's diverse needs were not always fully assessed and planned for and this important information was not always available to staff. For example; one person's records we viewed stated that they were White British. However, when we spoke with the person, we found that this information was incorrect. The person's cultural needs had not been accurately assessed and planned for in order to allow staff to provide a personalised service to them. Some people's care plans did not contain information about their life history information or other diverse needs such as sexuality and people's sexual orientation was not detailed in their care records. This meant that improvements were needed to ensure people were receiving a fully personalised service in all aspects of their life.

Some care plans that we viewed contained information about people's preferences and detailed information about their care and support needs, so staff did have information in order to provide personalised care. People told us that they were involved in the development of their care plans but no-one could tell us they had been involved in reviews. One person said, "I was asked about my needs and choices and have got a care plan which I was involved with but I've not been involved in a review. I think it needs to be changed. I think I need a review as it's seems to me that different groups of carers do 'care' differently." The provider had plans in place to review and update all people's care plans and a new care planning system called 'Me and My Care' was going to be introduced. The regional manager told us this has been implemented in some of the provider's other homes with success as it encouraged the person and their family to be actively involved and provide information and photographs about the person's life history and choices so that staff had more detailed and meaningful information to help them provider personalised support. The acting manager was not aware of the Accessible Information Standard but told us that no-one had a need for specialist communication and if anyone did, this need would be met. The provider had recognised the need for improvement in care planning documentation but was working on other priorities before the new system was implemented.

At the time of our inspection, no one was receiving end of life care. However we found that people's wishes and preferences for end of life care had not been consistently recorded. One person had recently passed away after receiving end of life care at the home and there was no record of their own preferences for end of life care, only that of their family, which meant there was a risk that people may not receive the care they would have wished for at the end of their life. We saw that people had access to the medicines and health professionals required to ensure they had a pain free and comfortable free death.

People were supported to take part in activities that they enjoyed and had choices about how they spent their time. We saw that some people enjoyed taking part in a movement to music class on the morning of our inspection and craft activities and games in the afternoon. There were activity staff employed solely to support people with activities and there was a diary displayed in the home which showed the planned events and included one to one time for people who did not enjoy group activities. One person told us, "The

activity person spends quite a lot of time doing one to one activities with people including me. I want to work on my legs so I can walk again and she is helping me with that. I also like stitch craft and she starts me off on that and I really enjoy it. Other than that I like to stay in my room and watch television." We saw that Holy Communion was provided on the day of our inspection by a visiting minister and this was planned regularly. One person returned from Holy Communion and told us, "I love going to Church, I used to go every Sunday, I love it, I still do!"

People told us they would feel comfortable to complain if they needed to. One person said, "I know how to make a complaint or raise any concerns and would feel totally happy doing this if necessary." Another person said, "If I felt concerned I would tell one of the permanent carers, there are several I know I could trust with anything or I would ask to see a manager." We saw that information about how to make a complaint was displayed around the home including up to date contact information for the registered manager and regional manager. We saw that there was an appropriate complaints policy in place and complaints were dealt with in line with the provider's policy.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection we found that improvements were needed to ensure the service was consistently well-led and audits in place had not been effective in identifying the areas of improvement needed. At this inspection we found that improvements were still needed and a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified.

There was a registered manager in post; however they were not at work at the time of the inspection and they have since left the provider's employment. The local authority had received concerns about the safety and quality of care being provided at the service. These concerns were being investigated and at the time of the inspection, the service was not receiving new admissions of permanent residents. The provider also had a contract with the local clinical commissioning group to provide short term care to some people. There was an acting home manager in place and the regional manager provided support to the service for part of the week. There were also 'supporting managers' who worked for the provider and were providing the service with additional support in key areas such as care planning and people's experiences.

Systems were not effective at ensuring people were protected from avoidable harm. The local authority and the clinical commissioning group had fed back their concerns regarding this. We also fed back during our visits in January 2018 that there were concerns about the identification, investigation and reporting of alleged safeguarding incidents such as unexplained bruising. During our visit in February 2018 we found that the same concerns were ongoing and effective systems that protected people had not been established. A body map folder had been implemented so completed body maps were stored in this folder. When we discussed this with the acting manager and deputy manager they were unaware of this folders existence. The regional manager explained the staff had started using this to avoid losing any body maps among any other paperwork. However, people had still not been protected as concerns were still not reported to the local safeguarding authority and action to reduce the risk of reoccurrence had not been taken. This meant ineffective action had not been taken by the provider to protect people from avoidable harm which left people at a continued risk to their health and wellbeing.

The provider had not ensured that required improvements were made and sustained in order to achieve a good rating following the last inspection. Whilst the provider had audits in place to help ensure that issues with safety and quality were identified and acted upon, these had not identified the improvements required in a timely manner. For example, some care plans we viewed were out of date. We saw that care plans had been reviewed but the reviews did not identify where improvements and updates were required and therefore some people's care plans remained out of date. We saw that audits of medicines had been in place for some time but until very recently these had not looked at topical creams and therefore had not identified the issues that we did during the inspection with enough time to fully implement successful changes. A daily check was in place to ensure the stock of controlled drugs was correct which was recorded in a book. We saw some gaps in recording so we could not be sure these checks were taking place as planned. One page we viewed had red pen indicating it had been checked on a particular day. It was unclear whether the gaps had been identified and what action had been taken to ensure controlled drugs were being checked in line with the provider's processes and to reduce the likelihood of gaps occurring again.

Following the date of this audit there were further gaps in recording. This meant the audits had not been effective in ensuring appropriate checks were made and the provider's systems followed.

Systems in place did not always effectively monitor and mitigate risks to people. For example, the deputy manager and acting manager were unaware that planned 30 minute observations were not being carried out for one person who was identified as being at high risk of falls. The deputy manager was also unaware that no action had been recorded in relation to one person's unexplained bruising, until we pointed this out to them during inspection. The local clinical commissioning group had informed us that they recently found unexplained bruising to another person and no action had been taken or recorded to safeguard the person. Despite concern raised from the clinical commissioning group about this issue, we found similar incidents had occurred again on both our January and February visits which meant that the systems and processes in place still did not effectively monitor risks to people's safety and improvements made to the system had not been successful. Another person had their care plans reviewed following feedback from our visit in January. However, the review had failed to identify the risk to the person and to take action to mitigate the risk from the person climbing over their bed rails. Another person had been prescribed antibiotics but they would consistently refuse them but this had not been identified as an issue and concerns had not been raised to a GP to consider other options. This meant that systems in place to monitor and mitigate risks were not always effective.

Handovers were not effective in ensuring all staff had the most up to date information so that people received safe and consistent care. For example, the management were not aware of some bruising that had been documented despite it being on the handover. This meant timely action had not always been taken to protect people. One person was moved from their normal bedroom to another bedroom the evening prior to our visit on 9 February 2018 due to a fault with their airflow mattress; however this was not on the handover and the faulty mattress had not been reported to the maintenance team via the maintenance log available on each floor. This had caused a delay in the person being able to go back onto their specialist mattress to help protect their skin, which put them at increased risk of skin damage. Another person had previously had a catheter fitted. This had since been removed however some staff were not aware of this. This meant the person was at risk of not receiving care in line with their needs or inconsistent care as some staff may not realise the person needed to visit the toilet. Due to agency staff being regularly used and guidance not being available to regular staff, coupled with ineffective information sharing, there was a risk that people might not be supported according to their needs which put their health and wellbeing at risk.

An incident had occurred after our visits in January 2018, which prompted us to revisit the home in February 2018 to continue the inspection. We came to check if appropriate action had been taken to reduce the likelihood of issues occurring in relation to the use of medical equipment when supporting people. Permanent nursing staff told us and we saw evidence of them receiving extra training and competency checks in relation to the use of particular equipment. However, agency nursing staff had not all had the same level of support but were still working shifts within the home. We were told checks had taken place on medical equipment in the home to ensure it was all fit for purpose. However we found multiple items which were not fit for use as they were unsterile when they should have been sterile or they were out of date. A daily check had been implemented on some equipment so that staff would sign they had ensured it was fit for purpose each day. However we found that these checks were not being recorded so we could not be sure they were being completed. We observed a faulty wheelchair being used by staff to support people to move around the home however, it had no brakes. We observed a person being anxious whilst getting out of the chair, as it was unsteady. The staff member did not remove the equipment from use so people could have continued to use this. We asked the deputy manager and a member of maintenance staff about the wheelchair and they found that it was not the property of the home so should not have been used. This meant checks on equipment and actions that had been implemented were not always effective in ensuring

equipment was fit for purpose and readily available for use to protect people's health and wellbeing.

The above evidence shows that systems and processes had not been operated effectively to ensure that people received consistently safe and good quality care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our immediate concerns to the provider and they developed an action plan. The provider also met with us to discuss how they were going improve the service and what actions they were going to implement immediately to ensure people's experience of care improved and a continuous plan for improvement was put into place.

People and relatives told us they recently had meetings where they had been able to provide feedback and receive information about changes within the home. However, people told us that these meetings had not previously been regularly happening. One person said, "It's funny you should mention that as we had a meeting last week, I'm not sure if this is regular as I can't remember having any before." A relative said, "We had a relatives meeting last week. It's the first one as far as I know since my relative came here in March. I've never been asked for any other feedback about care such as surveys." The regional manager told us that another meeting for people and relatives was planned as some had requested that evenings would be better for them. We saw that action was being taken in response to people's feedback. A 'You said, we did' board communicated that people had requested more craft activities which we saw had been planned and were taking place on the day of the inspection. This showed that people were being given opportunities to provide feedback and this was being acted upon.

The provider was working to promote a more open, inclusive and positive culture. Staff told us that improvements were being made and that they recently felt more included in the running of the home. Staff had a positive attitude towards the additional management support from the provider. Comments from staff included, "I feel listened to now. The recent staff meeting was the first one I'd been to", "New people [management] coming in are approachable, it's a much better place to work, staff attitudes have changed and we are working as a team" and "Things are now being put into place that should have been. It's moving forward." This showed that a positive culture to deliver high quality care and support was developing.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People's risk were not always suitably managed to ensure they remained safe. |

**The enforcement action we took:**

We imposed a condition on Hilltop Manor's registration. The condition is: On the last Friday of each month the registered provider must submit to the Care Quality Commission a written report setting out their own evaluation of progress against the action plan dated 15 February 2018.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not always protected from avoidable harm as potential safeguarding incidents had not always been investigated, reported or action taken to reduce the likelihood of them reoccurring. |

**The enforcement action we took:**

We imposed a condition on Hilltop Manor's registration. The condition is: On the last Friday of each month the registered provider must submit to the Care Quality Commission a written report setting out their own evaluation of progress against the action plan dated 15 February 2018.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes in place to monitor and improve the safety and quality of services were provided were not always effective in driving continuous improvement. |

**The enforcement action we took:**

We imposed a condition on Hilltop Manor's registration. The condition is: On the last Friday of each month the registered provider must submit to the Care Quality Commission a written report setting out their own evaluation of progress against the action plan dated 15 February 2018.