Hillview Care Limited

Cornelia Manor RCH

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection. Cornelia Manor provides accommodation and personal care for up to 34 people, including people living with dementia. At the time of our inspection 29 people were living at the service. The service had a registered manager in place. 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.

We found people's safety was being compromised in some areas. This included the way incidents of abuse were responded to by staff which meant people were not always protected from abuse. We also found there were not enough staff to keep people safe at all times. The

Summary of findings

provider had not made an application under the Deprivation of Liberty Safeguards for a person who was subjected to restrictions that could have amounted to a deprivation of their liberty.

Staff were not always following the requirements of the Mental Capacity Act, 2005 (MCA). The recording of decisions following MCA assessments was not consistent. Meetings had not been held to make sure the best interests of people who lacked capacity to make decisions were considered, for example in relation to the use of medicines being given in a covert way.

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of people using services and take regulatory action where required. We identified six incidents of abuse, or allegations of abuse, of and by people living at the service which had not been reported to CQC.

Most people spoke highly of the staff and told us they were treated with compassion. One person told us of two staff members had "wonderful laughs" and "make the place feel very happy". A visiting healthcare professional said "people are treated well". However, two people told us they did not always feel respected and one person's dignity was compromised by their bedroom door having to be kept open to keep the room cool.

Staff maintained records to monitor whether people's nutritional needs were being met. However, although staff told us people could ask for alternative meals, two people who asked for a cold lunch were told they were not available. People had access to a range of group activities, but no provision was made for people who chose not to join in with such activities. This put some people at risk of social isolation.

There was a comprehensive system in place to regularly assess and monitor the quality of service people received. However, it had not identified the concerns we found during this inspection as it focussed on processes rather than outcomes for people.

Risks of people falling were managed effectively and equipment was being used safely. Records were maintained to show people at risk of developing injuries due to sitting or lying in the same position were turned regularly and pressure relieving cushions and mattresses were being used.

Care plans were personalised and staff knew how to support people according to their individual needs. People were supported to have access to healthcare services and healthcare professionals praised the quality of care provided. People told us their needs were fully met and they were looked after well.

Necessary checks were undertaken to ensure staff were suitable to work with people. Emergency procedures for fire evacuation were in place and understood by staff.

The provider conducted yearly surveys of people, their families and professionals to ascertain their views. People knew how to make complaints and these were dealt with promptly. Feedback provided from surveys, comments and complaints was used to improve the service.

With the exception of incidents of abuse, investigations of other incidents and accidents were prompt and thorough. Learning was identified and passed on to staff to reduce the likelihood of similar incidents occurring again.

Feedback from people, relatives and staff showed the service had a positive, open culture. People were asked for their views and these were used to improve the way the service was run. Visiting relatives and friends were made welcome and staff engaged well with external professionals. Staff told us they enjoyed working at the service, felt it was well-led and spoke positively of senior management.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

Following the inspection we spoke with staff from the local safeguarding authority to discuss some of the concerns we had identified.

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?

Inadequate

Some aspects of the service were not safe. People were put at risk because incidents of abuse were not responded to appropriately and there were not enough staff at certain times of day.

Procedures had not been followed to ensure Deprivation of Liberty Safeguards were put in place for people who were not permitted to leave the building unaccompanied.

The service followed safe recruitment practices and appropriate emergency procedures in the event of a fire were in place.

Is the service effective?

Good

People were provided with effective care by staff who were appropriately trained and supported.

People told us their care and support needs were fully met. They were supported appropriately to eat and drink sufficiently.

Monitoring charts were used effectively to identify any changes in people's health. Where necessary, people were referred to healthcare professionals such as GPs and community nurses. Healthcare professionals praised the quality of care provided by the service.

Is the service caring?

Requires Improvement

The service was not always caring. Most people told us they were treated with compassion, although two people said they did not always feel respected. The dignity of one person was compromised at times.

Interactions between staff and people were warm and friendly. Staff were aware of people who wished to be cared for by female staff. However, the information was not recorded in care plans, so there was a risk that people's wishes may not have been met consistently.

Is the service responsive?

Requires Improvement

The service was not always responsive. Two people were not provided with an alternative meal when they asked for it. The recording of decisions following mental capacity assessments was not consistent, and, where people lacked the capacity to make decisions, meetings were not held to make sure decisions were taken in their best interests.

A broad range of group activities was provided, but there was no provision made for people who chose to stay in their rooms. This put some people at risk of social isolation.

Summary of findings

Care plans were personalised and action was taken when people's needs changed. A survey of people and their families showed they were satisfied with the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. Incidents of abuse had not been reported to CQC as required so the way the provider dealt with the incidents could be monitored.

Feedback from people, relatives and staff showed the service had a positive, open culture. Visitors were made welcome and staff told us they enjoyed working at the service. They told us team work was good and management were approachable.

Effective procedures were in place for the reporting of accidents and incidents. A comprehensive quality assurance system was in place to assess and monitor the quality of service that people received. However, the system was process based and had not identified concerns found during this inspection.

Cornelia Manor RCH

Detailed findings

Background to this inspection

We spoke with 11 people using the service and three family members. We also spoke with seven members of staff, the provider, two visiting healthcare professionals and the registered manager. We looked at care plans and associated records for nine people and viewed records about staffing and how the service was managed. We observed care and support being delivered in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of an inspector, a specialist advisor in mental health and dementia, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications we had been sent. A notification is information about important events which the service is required to send us by law.

The previous inspection of the service, in April 2013, found no areas of concern.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

We identified six incidents, between December 2013 and April 2014, where people had been abused, or made allegations they had been abused, by other people living at the service. The manager had initially put some measures in place to protect people, including installing a device to alert staff when the suspected abuser left their room. However, the measures had not been effective as they had not prevented a vulnerable person entering this person's room. Following these incidents, the manager took additional action which records showed had prevented further occurrences. Incidents of abuse are required to be reported to the adults safeguarding team of the local authority, so they can be investigated and action taken to ensure appropriate safeguards are put in place to protect people from further abuse. The provider did not respond appropriately to incidents of abuse as none of the above incidents had been reported to the safeguarding adults team as required.

Although the manager told us that no one living at the service was subject to deprivation of liberty safeguards (DoLS) and that nobody was being deprived of their liberty, we found at least one person was. Staff told us this person often tried to leave but was unable to do so as the doors were locked. Staff told us this person would not be safe if they were allowed to leave the building unaccompanied and said the person lacked the mental capacity to understand this. The manager was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty and told us they were planning to discuss this with the Head of Care. However, they had not sought advice from the relevant authority or made an application for a DoLS authorisation for this person or other people who the guidance might apply to.

The above issues were a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us staff were "always busy", particularly in the afternoons. One person said, "They are a bit slow to answer the call bell sometimes." Another person told us, "They are short sometimes, often in the afternoon." Three members of staff told us there were usually three care staff working in the afternoons and that this was not enough. They said at tea time (5:00 pm), one staff member was busy with the medicines round, while the other two care staff supported three people to eat in their rooms. This meant other people were often left unsupervised in the dining room, where the majority of people ate. Staff told us this put people at risk of harm as they could fall or choke. They also said they rarely had time to talk with people on a one to one basis because they were too busy.

The manager showed us a tool they used to assess the number of staff needed. However, we found the tool was not used correctly as key information about people's needs had not been considered. The manager told us they worked an afternoon shift on the day before our inspection and felt the staffing levels were "comfortable". They said if staff were properly organised they had sufficient time to complete all tasks safely. However, they acknowledged that staff were unable to be flexible in the way they delivered care and support and had to be task-orientated at these times.

All care plans included risk assessments which were fully completed, relevant to the person and specified actions required to manage risks. These included the risk of people falling or developing injuries due to sitting or lying in the same position for too long. We observed equipment, such as bed rails and hoists, being used safely and in accordance with people's risk assessments. Records showed assessments were updated on a monthly basis and changes made where required. Changes were highlighted on a 'handover sheet', so staff coming on duty would be aware of them.

With the exception of the people involved in the incidents of abuse mentioned above, records showed that risk assessments and care plans for other people who displayed behaviour that could challenge others were effective. Staff were well-informed about the needs of these people and understood what they needed to do to support them. Entries in daily records of care confirmed people received appropriate support.

Recruitment practices were safe. They included the use of application forms, an interview, reference checks and criminal record checks. Staff files for three staff members who had recently been recruited confirmed the service's procedures had been followed. The manager had clear procedures in place for managing staff absence and described how these had been used, in conjunction with the provider's disciplinary procedures, to take action when attendance levels were not satisfactory. They told us such

Inadequate

Is the service safe?

action had helped reduce staff sickness levels. The manager told us how they had also used the provider's disciplinary procedures to take action in respect of two members of staff who were unsuitable to work with people who used the service. Records showed action was taken promptly to ensure people's safety.

Emergency procedures in the event of a fire were in place and understood by staff. Records showed fire safety equipment was regularly checked and serviced. Fire alarms and drills were held frequently and staff were clear about what action to take in the event of a fire. Evacuation information was displayed on notice boards in people's rooms and personal evacuation plans were being developed for each person to ensure key information was available in an emergency.

Good

Is the service effective?

Our findings

People told us they liked the food and staff usually provided alternatives when they were requested. One person said, "The food is very good. I do like beans on toast and they will always do that for me." A family member commented, "excellent food, I have eaten here." However, another person told us "The food is quite good and has improved in the last two weeks."

People had enough to eat and drink throughout the day and night. There was a weekly menu plan showing varied and nutritious meals with a choice of two main meals each day. People had access to jugs of cold drinks in all communal areas and in their rooms. Suitable drinking containers were provided according to people's needs. The jugs were refreshed regularly throughout the day. In addition, staff operated a morning and afternoon drinks trolley supplied hot and cold drinks and people told us they could access additional drinks whenever they needed them.

People who needed one-to-one support to eat and drink received it and staff took time to allow people to eat at their own pace. People who needed lower levels of support were encouraged and prompted to eat a sufficient amount. Catering staff were aware of people who required special diets and were clear about how they should be prepared. Where people needed their food to be cut up for them at lunchtime, staff showed the meal to the person first and, where necessary, described it to the person before it was cut up in front of them. This helped ensure people were aware of what they were eating.

Food and fluid charts were in place for people at risk of receiving inadequate nutrition. These were completed immediately after people had had their meals and drinks, which staff told us was to ensure they were "as accurate as possible". Fluid charts were totalled daily and a "fluid guide" in people's care plans provided advice to staff about how much a person should be encouraged to drink. Records showed people's weight and body mass index were monitored regularly. Although there were some discrepancies, caused by difficulties weighing some people, staff were clear about which people were at risk of malnutrition or dehydration and appropriate referrals had been made to specialists where necessary.

The induction and training programme for staff was comprehensive and ensured all staff had the knowledge and skills necessary to carry out their roles. Records showed training was provided in key subjects, such as moving and handling, infection control and medicines. Some staff had also completed training in other relevant subjects, including end of life care and diabetes management.

The manager told us staff were in the process of completing a series of computer based competency assessments to test their knowledge in key areas. The results were being used to identify training needs, which were then met by appropriate means; these included attending a training event, discussing the subject with the manager and one-to-one shadowing of experienced staff. Staff's competence in moving and handling, medication and infection control was assessed by regular observations by senior staff. The assessment processes made sure staff had the necessary understanding to be able to deliver care effectively. However, two members of staff told us they did not feel supported in relation to the completion of their competency assessments. They said, and the manager confirmed, that these had to be completed either at home or by attending work in their own time, which they thought was "not right".

Staff received one to one supervision every two months, in line with the provider's policy. Discussions during supervisions considered the staff member's personal development and training needs. Staff who had been employed for over a year had also received annual appraisals.

People were supported to access healthcare services and were involved in the regular monitoring of their health. Records showed people had been referred to GPs, community nurses and other specialists when changes in their health were identified; for example, when their blood sugar readings varied from the norm. We spoke with a visiting dispensing optician who told us they were contacted appropriately when people needed their eyesight testing. They described staff as "organised". The system used to ensure people were supported to attend hospital appointments was effective. A separate duty sheet was kept for this purpose and additional staff were called in to accompany people where this was necessary. Records showed this had resulted in high levels of attendance for appointments.

Requires Improvement

Is the service caring?

Our findings

The dignity of one person was compromised by their bedroom door having to be kept open. Staff told us this was to keep the person cool as the weather was very hot at the time of our inspection. On several occasions during the course of our inspection we saw the person laid on their bed in a state of undress. We brought this to the attention of staff and they repeatedly covered the person with a sheet, but the sheet did not stay in position for long. Other solutions, such as the use of a fan or a screen, had not been explored. On other occasions, when people's clothing became undone, staff intervened quickly to cover them up and restore their dignity. We also saw staff knocking on people's doors before entering and closing doors before providing any personal care.

Two people told us they did not always feel respected. One person said, "They [the staff] think nothing goes through my head but it does." Another person told us "Staff are quite good but one treats me like a five-year-old." This showed some people were not always treated in a way which made them feel respected and valued. However, other people told us they were treated with compassion. One person said they were "very happy" and "would not want to leave". Another person described staff as "caring".

Comments in care plans and monthly reviews of people's care showed they and their relatives were involved in discussing and planning their care and treatment. People's preferences, likes and dislikes were recorded in care plans, support was provided in accordance with people's wishes and staff called them by their preferred names. Staff were aware of three people who had expressed a preference to be cared for by female care staff and told us their wishes were always met. A note on the "handover sheet" alerted staff to the latest person who had expressed this preference. However, people's preferences were not recorded in their care plans so there was a risk their wishes may not have been met consistently.

Interactions we observed between staff and people were kind and friendly. One person told us of two staff members in particular who they said had "wonderful laughs" and "make the place feel very happy". They said they often saw the provider, who "checks we're OK and says if there's anything at all we want, just ask". A visiting healthcare professional told us they got a "good feel" from the service and said, "people are treated well".

People's relatives and friends were able to visit whenever they wished. On both days of inspection we observed a number of relatives and friends visiting people at the service. Family members told us they were always made welcome and offered drinks. Comments made by people in a recent survey conducted by the provider were complimentary. These included "Staff very friendly, helpful and easy to talk to" and "Staff always friendly and welcoming".

Requires Improvement

Is the service responsive?

Our findings

Assessments of people's mental capacity were made when people first moved to the service in relation to their ability to make decisions about their care and treatment. However, the recording of these decisions was not consistent. For example, one person who had been assessed as lacking the capacity to make decisions about their care had subsequently signed a review document about their care and a 'last wishes' form. In another case, a person was assessed as having capacity to make decisions but had refused to sign their care plan. Their care record showed that because the person had refused to sign the care plan, a family member had signed this to show their agreement to the person receiving the care and treatment planned for them. In another care record, a family member had signed a form about decisions relating to the last wishes of a person who had been assessed as capable of making their own decisions. There was no evidence to show these decisions had been discussed with, or were acceptable to, the people concerned.

Where people lacked the capacity to make decisions about their care and treatment, best interests meetings had not been held to make decisions on their behalf. For example, the GP had written to the service to say that one person could receive their medicines in a covert (hidden) way; however, neither the GP nor the service had completed an assessment to consider whether this was in the person's best interests; neither had the pharmacy been consulted to advise on whether this was safe and nor was the person or their relatives involved in the decision.

The manager told us staff had received training in the Mental Capacity Act, 2005 (MCA) but that subsequent testing had shown that their knowledge levels did not meet the required standards. They told us they were planning further training sessions to address this. We were not assured the service was meeting the full requirements of the MCA and its code of practice.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service was not always responsive to people's requests for alternative meals. When two people asked for a salad on the first day of our inspection, they were told there was "no option today, it's roast pork". The inspection took place in the middle of the summer on one of the hottest days of the year. Staff told us they were still using the "winter menu" and had not introduced the "summer menu" yet. One person said, "You don't need a hot meal in this weather." A family member said, "I hope they may be able to offer some salads or cold meals with the summer." The manager told us the lack of a summer menu was due to changes in the catering staff and said a summer menu would be introduced in the near future. They told us they had bought ice lollies and choc ices for people, which were popular.

A broad range of group activities was provided throughout the week and was advertised on notice board. These included singing, games and quizzes. We observed people in the main lounge taking part in an activity which involved tasting and identifying fruit and vegetables. People and staff were seen interacting, laughing and enjoying the activity. Other activities included trips to local attractions and a picnic had been arranged recently. However, the activity needs of people who chose not to engage in group activities and who preferred to stay in their rooms were not always catered for. One person told us "I have nothing to do except watch TV and it would be nice for someone to come and talk to me." This put some people at risk of social isolation.

People told us their care needs were fully met. One person said, "Everyone is great. Things are as good now as when I arrived a year ago." A family member told us "The service is exceptional." Three other people said they liked living there, staff were "very good" and they felt "well looked after."

When we asked staff about people's needs, they were able to give us up to date information about all aspects of people's care and support. They were clear about the need to support people to make choices and promote their independence. One staff member told us "We take a person-centred approach and go with [people's] choices and decisions." Care plans provided comprehensive information about people's care and support needs and how they should be met. On admission, people's needs were assessed over a period of weeks, during which time their care plan was developed and refined. Summary care plans, provided key information about people's needs, were also available to staff which they told us were "excellent" and "easy to follow". Daily records of care

Requires Improvement

Is the service responsive?

provided showed people received care and support in line with their care plans. A visiting healthcare professional told us "This is one of the best homes I visit. I've no concerns. People are well looked after."

Care records showed action was taken when people's health needs changed. For example, one person's ability to eat had changed and the action staff needed to take to support the person had been clearly reflected in their care plan and risk assessment.

The provider conducted yearly surveys of people, their families and professionals. These showed people were satisfied with the service. Comments from the most recent survey included "It's great comfort to know [my relative] is ending their days somewhere she is loved, respected and well looked after"; "[My relative] appears happy and well cared for"; and "skill levels consistently high". The manager had developed action plans following the analysis of the results of the survey in response to people's comments.

People were given information about how to make complaints. People told us they were aware of this and that if they had any concerns they would speak with the manager or head of care. One person said, "I have no complaints whatsoever." Complaints received by the service were dealt with in a timely manner and in line with the provider's complaints policy. For example, a complaint about a temporary lack of hot water had been responded to directly by the provider, who met with the person and resolved the matter within five days. The complaint was fully documented and the outcome recorded.

People were encouraged to take part in residents' meetings, where they could express their views about the service and the care they received. Minutes of the latest meeting, held in July 2014, showed a range of issues were discussed including the laundry, activities and menus. Changes had been made as a result of residents' comments, including improvements to the activity programme and the way some food was cooked.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to notify CQC without delay of certain incidents which occur. These include deaths, serious injuries, abuse and allegations of abuse of people. Our records showed that all deaths and serious injuries to people had been reported as required. However, six incidents of abuse, or allegations of abuse had not been reported to CQC. Therefore, CQC was not able to monitor whether these incidents were dealt with appropriately and to take appropriate regulatory action if required to ensure people were safe. The manager told us this was an oversight as their focus had been on supporting the complex needs of the people involved.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009).

A comprehensive system was in place to regularly assess and monitor the quality of service that people receive through a series of audits. These were broken down into specific areas of quality and safety. Each area was audited between one and four times each year. An evaluation of the results of these audits was conducted and used to identify areas of improvement. Action plans with timescales were then developed to ensure improvements were made. However, the auditing system had failed to identify all the concerns we found during this inspection as it was focussed on processes rather than the outcomes for people.

Staff told us they enjoyed working at the service, felt it was well-led and spoke positively of senior management. One staff member described the culture of the service as "effective and supportive". Another said of the management, "They're always there if you need them and always listen to your problems." Experienced members of staff told us teamwork was good and managers were approachable. One staff member said the provider had written to all staff informing them that if they had any concerns they could raise them directly with them. The staff member described this as "very positive and very helpful for staff".

Feedback from people, relatives and staff showed the service had a positive, open culture. The manager had an "open door" policy and people and staff regularly approached them with questions or concerns throughout our inspection. Staff engaged well with external professionals and an appropriate whistle blowing policy was in place, which staff knew how to use. Most people had family members living near the service. The service welcomed visits from them and encouraged people to maintain their links with the local community.

A registered manager had been in post for three years. Records showed a senior representative of the provider was actively involved in the running of the service and held regular meetings with the manager, which were documented. Minutes of the meetings showed clear actions were identified to address concerns or improvements in order to ensure the effective running of the service.

We observed a staff briefing on the morning of the first day of our inspection. Staff were updated about people whose conditions had changed and were assigned to specific roles for the shift. The briefing was effective and well organised. Staff were well-motivated and clear about their roles and responsibilities.

Minutes of staff meetings showed these were held regularly and gave staff an opportunity to raise concerns and make suggestions for improvements. For example, in one meeting the promotion of people's dignity was raised by staff and changes had been made to the way continence products were stored as a result.

Clear internal procedures were in place for the reporting of accidents and incidents. With the exception of incidents of abuse, investigations of other incidents were prompt and thorough. For example, during the inspection a person suffered a mild injury caused by a hot cup of tea. The manager took immediate action to record and investigate the matter; they provided appropriate advice to the staff member involved to prevent a recurrence. A file of other incidents was well organised and demonstrated all incidents were reviewed by the manager. Learning was identified and passed on to staff during one to one supervisions or used as case studies for discussion at staff meetings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining the consent of service users in relation to their care and treatment. Regulation 18.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified CQC of all incidents of abuse in relation to service users. Regulation 18(1) & 18(2)(e).**