Hillcrest House Limited

Hillcrest House

Inspection report

Barbican Road
East Looe
Cornwall
PL13 1NN

Tel: 01503265151
Website: www.hillcrestlooe.co.uk

Date of inspection visit:
07 December 2016

Date of publication:
26 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 7 December 2016 and was unannounced. The last inspection took place on 29 & 30 September 201. At that inspection we asked the provider to take action to make improvements to how care was provided to people living with dementia, the deployment of staff and auditing systems. The provider sent the Care Quality Commission an action plan outlining how they would address the identified breaches. At this inspection we found the actions had been completed.

Hillcrest House is a care home with nursing for up to a maximum of 88 predominately older people. At the time of the inspection there were 66 people living at the service. Some of these people were living with dementia. The building is split into two units known as, the general unit and Trevena. Trevena is for people who are living with dementia. The general unit is based over two floors. One of the floors is for people who have nursing needs and the other is a residential floor.

The service is required to have a registered manager, there were three registered managers in place. 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. The registered managers had clearly defined roles and areas of responsibility. They were supported by a compliance and quality assurance manager, a clinical lead based in Trevena and a deputy matron based in the general unit.

The service was exceptionally caring. Management and staff valued the importance of personal relationships to people and were committed to supporting them. Families and friends were welcomed into the service at any time and encouraged to join their loved ones for meals. Staff worked to develop relationships with people and demonstrated an understanding of their needs and backgrounds. The way in which care was delivered reflected people's individual preferences.

People's preferences were identified and respected in all areas of their lives. There were systems in place to seek out people's opinions about the way in which the service was run. Two people had been nominated as ambassadors and their role was to speak to others about the service they received and feedback any concerns or potential areas of improvement to the management team.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were assessed and planned for to minimise the risk of harm. There were sufficient numbers of staff to help ensure people's needs were met. Domestic staff had received additional training so they were able to support people during meal times and alleviate the pressure on care staff at this busy time.

People were supported by a team of staff who were skilled and given on-going training and opportunities to develop. People's rights were protected because staff acted in accordance with the Mental Capacity Act

2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly.

Improvements had been made to the environment. These had been carried out to meet the needs of people living with dementia. There was clear signage, particularly in Trevena. Seating had been arranged to encourage social interaction.

Care plans were well organised and contained accurate and up to date information. Care planning was reviewed regularly and people's changing needs recorded. Where appropriate, relatives were included in the reviews.

People had access to meaningful activities. Four activity co-ordinators arranged regular events and pastimes for people. These included competitive sports, pampering sessions and craft sessions. They also co-ordinated organised visits from outside entertainers. The management team worked towards social inclusion and was committed to developing and maintaining strong links with the community.

The management team kept up to date with any developments in the care sector and any research into dementia related conditions. They demonstrated a commitment to driving continual improvement within the service and enhancing people's lives.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to recognise the types and signs of abuse and were confident about reporting procedures both in and outside of the organisation.

There were enough staff to meet everybody's needs in a timely fashion.

Systems for the management of medicines were robust.

Is the service effective?

Good

The service was effective. Staff were well trained and regularly supervised.

The service was meeting the requirements laid down in the Mental Capacity Act (2005) and associated Deprivation of Liberty safeguards.

People had access to a varied and nutritious diet.

Is the service caring?

Outstanding

The service was extremely caring. Staff approached people with kindness, consideration and respect.

People were recognised as individuals with their own unique interests and preferences.

The importance of people's personal relationships was recognised and respected.

Is the service responsive?

Good

The service was responsive. People had access to a range of meaningful activities.

There were systems in place to help ensure any change in people's needs would be quickly identified.

Care plans were well organised and contained detailed information on people's health and social needs.

Is the service well-led?

Good

The service was well-led. The management team worked together to regularly review how the service was operating and made changes when necessary.

The opinions of people, their relatives and staff were sought out and action taken to put any improvements in place.

There was a positive ethos which emphasised the value of personal relationships.

Hillcrest House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out an unannounced inspection of Hillcrest House on 7 December 2016. The inspection was carried out by two adult social care inspectors, a pharmacy inspector 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 reviewed the PIR and other information we held about the home. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We met and spoke with ten people who lived at Hillcrest House and three visitors. We looked around the premises and observed care practices and interactions between staff and people.

We spoke with the two of the three registered managers, and thirteen other members of staff. This included the compliance and quality assurance manager, the clinical lead, deputy matron for the general unit, one registered nurse, eight care staff and the catering manager. Following the inspection we contacted a further two relatives and two external healthcare professionals to hear their views of the service.

We looked at care documentation for six people, medicines records, four staff files, staff duty rosters, training records and other records relating to the management of the service.

Good

Is the service safe?

Our findings

At our last inspection in September 2015 we found there was not always enough staff deployed to meet the needs of people living with dementia.

At this inspection we looked at staffing levels for the two weeks preceding the inspection and staff rotas for the following week. The management team had identified the staffing levels required to meet people's individual needs and these had been met on all but three occasions. We discussed this with the management team who told us there was always a senior member of staff on duty to help with care if needed. Staff told us they were able to work across units if required in order to make sure people were supported appropriately. Rotas for the following week showed there were two shifts to fill. The compliance and quality assurance manager told us, if they were unable to cover these shifts from the staff team, they would use agency staff who had experience of working at the service.

Staff told us there were enough staff to meet people's needs. On the day of the inspection people had their needs met quickly and staff spent time talking with people and checking on their general well- being. We observed the lunch time period on the Trevena unit. People who needed assistance to eat their meals were supported with consideration and without being rushed. Domestic staff had received additional training so they were able to help support people at meal times. This showed the provider had recognised the need for additional staff at key times of the day and had taken action to address this. One of the registered managers told us they continually reviewed staffing levels, and were flexible in the way they deployed staff, to help ensure they were able to meet people's changing needs. For example, staffing levels were increased when new people moved in to live at the service, to help them settle in.

The staff team had an appropriate mix of skills and experience. During the day there was always one registered nurse on shift on each unit. At night one registered nurse was on duty. A member of staff commented; There's always a good mix of skill sets." One person commented; "I feel there are enough staff, I only have to wait minutes for my call bell to be answered."

We concluded the provider was now meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they believed their family members were safe living at Hillcrest House. Comments included; "I can walk away from the home after my visits and feel happy with the care she is receiving" and "I don't have any complaints about her care and treatment, I have never heard or seen any kind of abuse, most of the staff are brilliant and they treat her with respect."

Care plans contained risk assessments for a range of circumstances including moving and handling, skin integrity and likelihood of falls. On admission to the service people were assessed over a range of areas and this was reviewed weekly for a period of one month. This helped ensure there was accurate information in place in respect of any risk. Risk assessments specific to people's individual needs were then developed and included in care plans. These were updated regularly to reflect people's changing needs. There was a lack of

written guidance in place for staff on how to care for someone who had been identified as at risk. For example, one person had been identified as being at risk of falls. There was no information for staff within the care plan on when this risk might be higher or what action they could take to minimise the risk. However, throughout the day we saw people were supported to move around safely and in line with best practice. One of the registered managers told us they had provided people with footwear which protected them from falling. This demonstrated the management team considered how to protect people from identified risks and took action accordingly.

People received their medicines in a safe and caring way. We watched some medicines being given at lunchtime, and saw that people were asked if they needed any medicines prescribed to be given 'when required', for example pain killers. There was no-one who looked after their own medicines at the time of our inspection. However there were systems and policies in place so that people could do this if they wished, and it had been assessed as safe for them.

There were clear records of medicines administered to people or not given for any reason. This helped to show that people received their medicines correctly in the way prescribed for them. There were separate charts with instructions for staff to record the use of creams or other external items. Medicated patches were recorded on separate charts detailing where they had been applied.

One person was prescribed a medicine that needed additional monitoring and regular blood tests. Staff kept the results of the most recent blood test and the current dose with the administration records. This meant that staff were able to ensure they always gave the correct dose. Since our previous inspection improvements had been made to the way information was recorded about 'when required' medicines. On one unit there were clear protocols for each person kept with their medicines records. These provided guidance for staff on when to offer or give these medicines to help make sure people received these medicines correctly, and when they were needed. These sheets were not in use on the other unit; however we found that information was recorded in people's care plans about these medicines, with guidance for staff as to when it would be appropriate to give them.

There was an audit trail of medicines received into the home and those sent for destruction. This helped to show how medicines were managed and handled in the home. Staff completed medicines checks and audits to help make sure that medicines were managed safely. The supplying pharmacy had also undertaken recent audits on both units. We saw that any issues with medicines were picked up, reported and handled appropriately.

Medicines were stored securely. Medicines requiring cold storage were stored in locked refrigerators. These were monitored to check that temperatures were suitable for storing medicines. The maximum temperature in one of these refrigerators was above the range required for storing medicines at the time of the inspection. Staff had picked this up, and provided evidence that the issue had been dealt with appropriately. There were suitable arrangements and records for some medicines that required additional secure storage.

Policies and procedures were available to guide staff, and information was available for staff and residents about their medicines.

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Any new staff had safeguarding training as part of the induction process and this was then regularly refreshed. The provider considered different approaches to the training to help ensure it was meaningful for staff. For example, a safeguarding quiz had recently been given to staff to complete. Staff told us they would report any concerns they had to a member

of the management team and were confident they would be addressed. The safeguarding policy contained contact numbers for external organisations where staff could raise their concerns if they were not satisfied with the action taken. An external healthcare professional told us; "They are very swift in investigating any concerns raised."

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of references including a reference from the previous employer.

We looked around the building and found the environment was clean and there were no unpleasant odours. Hand gel dispensers were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks. There were signs at the front door and entrances to the units reminding visitors to clean their hands on entering the building.

Some bathrooms in the general unit contained equipment such as wheelchairs, and other mobility aids. The equipment would need to be removed before the bathroom could be used. This meant people would not be able to access the rooms independently. The deputy matron commented; "We are lacking in storage." Other areas of the building were free from clutter.

Two maintenance workers were employed with a third due to start in the next few weeks. Any defects in the buildings were reported to the maintenance team and recorded in the maintenance log. Any health and safety issues were prioritised and dealt with as quickly as possible. Other faults were addressed quickly. Relatives told us the environment was always clean and well maintained. The maintenance team carried out regular checks on equipment such as wheelchairs and fire safety equipment. The head maintenance worker had received the appropriate training to enable them to carry out portable appliance testing (PAT) checks annually.

Personal Emergency Evacuation Plans (PEEPs) had been developed for people. These contained information to help ensure people could be supported appropriately to evacuate the building in an emergency. The PEEPS were kept at the reception desk so they were easily accessible if required.

Good

Is the service effective?

Our findings

At our last inspection in September 2015 we identified that people living with dementia did not always have their needs and preferences taken into account, particularly at meal times.

At this inspection we observed the lunch time period at Trevena and found people were supported according to their needs. Some people chose to wear clothes protectors while others declined. Care staff were observant to people's needs and chatted with them throughout the meal. Plate guards and special cutlery were given to some people to allow them independence. Two people required one to one assistance with their meal and this was given in a very friendly, caring manner. The care staff checked people were eating and drinking and gave gentle encouragement to those who needed it.

We concluded the provider was now meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The catering manager had a good knowledge of people's dietary requirements and preferences. They spoke with people regularly and were open to any ideas or requests. For example, two people had especially requested a food not popular with everyone and the catering manager had arranged for them to have this. This demonstrated people's individual preferences were sought out and action taken to accommodate them. Some people required their food to be pureed due to the risk of choking. Each component of the meal was pureed separately to retain the different flavours and make the meal visually appealing. This supported people's health as they were more likely to eat palatable foods and also contributed to making the meal time experience more pleasant for people. The kitchen was well stocked and products included branded goods. Boxes of snacks or "pickings" were prepared and left in the fridge if people wanted a snack in the evening. These included items such as cubes of brie and grapes. Staff had 24 hour access to the kitchen and were able to prepare food for people at any time. A recent environmental health food hygiene inspection had rated the home with the top score of five.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Applications for DoLS authorisations had been made where relevant and the service was awaiting the outcome of these from the local DoLS team. There were three authorisations in place at the time of the inspection. The conditions attached to authorisations were adhered to. Records showed best interest meetings were held appropriately. Staff had received training in the MCA and DoLS. A hand out explaining the basic principles of the legislation entitled; "A rough guide for

care workers" had been given to staff at a staff meeting in September 2016.

People were cared for by staff who had a good understanding of their needs and were skilled in delivering care. Relatives told us they considered staff to be competent. Training records showed staff had received training in areas identified as necessary for the service. Some staff had undertaken training in other areas specific to people's needs, for example end of life care. The compliance and quality assurance manager told us additional training could be arranged if necessary. For example, if people had specific health conditions. One member of staff told us; "We get training on everything, the face to face is very good."

Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with organisational policies and procedures. Staff new to care, or those who did not already hold an equivalent qualification, were required to complete the Care Certificate. This is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone.

Staff received regular supervisions and annual appraisals. A new system of peer supervision was also being used entitled, Reflective Observation of Staff Interaction & Environment. (ROSIEs). This involved nominated staff carrying out observations, either of staff practice or specific time periods such as meal times. They then reported their findings and action was taken to address any areas highlighted as needing improvement.

Each unit had a lounge area and basic kitchen facilities where drinks and light snacks could be prepared. There were other areas where people could sit and talk quietly with visitors with a greater degree of privacy. The service is a no smoking building, but the provider had considered the safety and comfort of people who wished to smoke. A door with a ramp led onto the garden and a sheltered area large enough for people in wheel chairs or scooters to sit and enjoy a cigarette safely and in the dry. One person commented; "I am so pleased to have this bolt hole to enjoy my smokes. It is good to come out here in peace, to have a cigarette." The provider told us in the PIR that the clinical lead had referred to The Kings Fund Project, 'Enhancing the Healing Environment' and other research when planning improvements to the environment. There was signage around the building to help people orientate themselves independently. This was particularly noticeable in Trevena, the unit used by people living with dementia. People had their names, and pictures which were meaningful to them, displayed on their bedroom doors which helped them find their own room. Bathrooms were clearly marked and coloured toilet seats had been fitted. These are easier for people with a visual impairment to see.

People had access to external healthcare professionals including GP's, opticians and chiropodists. Local GP's visited the service regularly. Staff responded quickly to any change in people's needs and referred them to the relevant healthcare professional. A relative commented; "If he needs a GP for the slightest thing they'll get one."

Outstanding ☆

Is the service caring?

Our findings

At our last inspection we made a recommendation that the provider consider research and published guidance in relation to the care of people living with dementia. At this inspection we found the needs of this group of people were very much taken into account. For example an experienced clinical lead who had extensive experience in dementia and mental health care, had been appointed to work in the dementia unit. They spoke with us about the use of validation therapy when working with people with dementia and the positive outcomes this could have. Validation therapy is a holistic therapy which focuses on empathy and building trust and security with people thereby reducing anxiety. The compliance and quality assurance manager was also the service's named dementia champion. They were affiliated with the Alzheimer's Society and had access to a range of materials and information to keep them up to date with any developments in best practice care and support of people living with dementia. This demonstrated people's specific needs were taken into account when planning how care was delivered.

External healthcare professionals and relatives were complimentary of the recent improvements made to the service. A healthcare professional commented on; "the enthusiasm and willingness [of senior staff] to learn more about dementia." A relative told us; "I have seen a terrific change in the whole atmosphere and care in the past year. I feel my [relative] is receiving the best care."

Relatives and people told us staff were very caring. Comments included; "They [staff] really care" and "They are all wonderful, I couldn't fault them." Staff told us they enjoyed their work and it was clearly important to them that people were happy. One told us; "I love making people smile." An external healthcare professional commented; "I see carers engaging in compassionate care with residents and they seem to be really enjoying their work."

During the day we found there was a relaxed and happy atmosphere within the service. We saw people were engaged in activities or interacting with staff and others. No-one appeared to be bored or dissatisfied. We did not hear people crying out for assistance or help or showing any prolonged signs of distress. When people did start to show signs of anxiety staff were quick to offer comfort, often spontaneously hugging people and giving tactile reassurances. This interaction worked each time and calmed the person down. An external healthcare professional told us they were impressed by the approach of a senior member of staff, describing it as; "non-judgemental, positive attitude to a newly admitted gentleman with a history of very challenging behaviour." This demonstrated a positive, accepting and caring approach to supporting people.

Staff constantly engaged with people as they went about their work, often spending time sitting and chatting with people. Staff were polite and friendly in their approach to people and we observed many examples of this. For example, two people were sitting together chatting and a member of staff approached one to ask if they needed any pain relief. They waited for a break in the conversation and then asked; "Sorry to interrupt, would you like a pain killer?" This simple act of politeness and consideration was reflective of staffs approach to people throughout the day.

In our conversations with the management team and staff it was clear they genuinely cared about the well-being of people living at Hillcrest House and worked to develop positive relationships with them and an understanding of people's needs. A member of staff said; "Every resident is different and we treat them as individuals, people are still people even when they have been diagnosed with some form of dementia." Care plans contained one page profiles which briefly outlined a pen picture of the person including information about what was important to them. This meant staff unfamiliar with the person were able to quickly get an overview of important aspects of the person's character.

The importance of people's personal backgrounds and life histories was recognised. We spoke with two members of staff who were discussing the recent funeral of one person. They showed us a picture of the person that had been used on the front of the Order of Service. This had been taken when the person was a young man. They talked about the importance of remembering people had lived full lives and; "Been young, just like us once." One of the members of staff said; Perhaps I could try and get pictures of people like this to use on their care plans. It would remind us of who they were once were."

One person had a tendency to pace and call out for people as if looking for them. Information in the care plan explained this was because of the person's previous occupation. There was clear guidance for staff on how they could reassure them. For example; "Settles well with validation therapy", "Will accept orientation and reassurance when he believes he has a meeting" and "Communicate slowly at eye level….place hand on forearm." This approach acknowledged the importance of the person's past life on their current behaviour and used that to find strategies to help the person become settled. A member of staff told us another person used to be a librarian and now liked to listen to talking books. They commented; "She gets snuggled down and listens to stories." In our discussions with staff, it was clear they knew people well and were able to respond to their individual needs and preferences.

The importance of personal relationships was recognised and respected. For example, we heard how one married couple had come to live at Hillcrest but, because of their conflicting needs, were unable to share a room on the same unit. Despite this arrangements had been put in place to enable them to share their lives in every other aspect. Staff ensured they spent as much time together as they wanted to and ate their meals together, and this had helped reduce their anxieties. The clinical lead told us; "We explain to [person's name] what is happening and why." This showed people's emotional well-being was considered. From our observations of the people involved and discussions with staff it was apparent this approach had had a positive impact on not only the couples emotional well–being but their mental and physical health as well.

We heard one relative making arrangements to come to stay at the service over the Christmas period so they could spend the holidays with their spouse. They told a member of staff they were a little concerned they would not be able to stay on the dates they wanted to. The member of staff assured them; "Don't worry about that, I will sort it out for you."

Information in care plans emphasised the importance of relationships to people. For example, "[Person's name] is very close to his wife and is missing her greatly" and "Loves his wife very much." A relative told us they were always welcomed at the service. They said; "[Person's name] tells me staff pop in and out all the time but when I am there they leave us alone. They want to give us some privacy."

People were also encouraged to develop new friendships with other people living at the service. The dining arrangements had been considered to allow people an opportunity to socialize. Large tables had been replaced by smaller ones which were grouped together. Visiting relatives were invited to join their family members for lunch. A member of staff told us; "We encourage relatives to visit and be involved, we want them to treat this as an extension of their home, if they are here at meal times we invite them to stay and eat

with us." Another commented; "Socializing regularly gives people security and confidence. It stops the isolation and fear."

There was a loneliness policy in place. This described the importance of tackling social isolation in care settings and summarised research findings in respect of this. It outlined what would be done to protect people from the risk of loneliness and isolation including bringing animals into the service and opening up to the wider community. An external healthcare professional told us; "I am aware of a recent admission in which the home made some environmental changes so that [the person] could bring his beloved cat." This demonstrated a willingness by the provider to make any necessary changes in order to meet people's preferences.

Two people whose health and well-being had been a concern to professionals had recently moved in to the service. One person in particular, had previously not been engaging with others and had become isolated. They were frequently distressed and had presented as anxious and fearful. Staff and management had worked to help ensure they were comfortable and had all their needs met. One of the registered managers told us; "We have seen loving kindness from our staff, just wanting to wrap their arms around them." Since their arrival the people's health and happiness had improved vastly. We saw pictures of one of them dancing at a recent event held at Hillcrest House. When we met with them they were talkative and humorous. A member of the management team told us; "[Person's name] is up and about and eating well. They have settled in really well." A member of staff told us; "As her confidence grew and her safety increased she blossomed." It was clear in our discussions with all staff that they genuinely cared for people's well-being.

People's preferences in respect of how their personal care was delivered was respected. Care plans contained detailed and personalised information. For example; "Encourage [person's name] to soak her feet as she does not like them being touched." Another person's care plan stated they felt self-conscious and uncomfortable receiving personal care. It directed staff to respect this and take particular care to protect the person's dignity at all times. Staff spoke with us about this particular person and demonstrated a compassion and empathy for their difficulty in this area. They described how they took extra time and care to help ensure the person was not embarrassed when being supported with personal care.

Bedrooms were decorated and furnished to reflect people's personal tastes. People had personal photographs and possessions in their rooms. All the rooms had a phone, connected to the main line to allow people to receive and make calls at any time. There were photographs and pictures hanging throughout the building which helped create a homely atmosphere. Christmas decorations had been put up and these were cheerful and eye catching. Seating in lounge areas was arranged in small groups to create an intimate, sociable and relaxed environment which encouraged conversation between people.

During the inspection we saw one member of staff doing a 'chocolate round' when people were offered a selection of chocolate snacks. The staff member told us this was done regularly as several people enjoyed a chocolate treat during the day. We saw thank you cards and messages which had been sent to Hillcrest House by relatives. Messages included; "We appreciated the patience you showed to [relative]."

Two people living at Hillcrest House had been appointed 'resident ambassadors'. Their role was to speak to others about the service they received and feedback any concerns or potential areas of improvement to the management team. They also helped any new people to settle in. This demonstrated people's views were actively sought out.

We found significant improvements had been made in the way in which people with dementia were supported and cared for. The recommendation made in our previous report had been acted on. Specialist

input from knowledgeable staff along with effective environmental changes had led to a relaxed and calm atmosphere where people were given loving care by skilled staff.

Good

Is the service responsive?

Our findings

At our last inspection in September 2015 we identified that people living with dementia were not always provided with opportunities for social stimulation which met with their individual needs, preferences and wishes.

At this inspection we found people had opportunities to engage in activities and pastimes which were meaningful and reflected their interests. A darts league and ten pin bowling league had been set up. A poster in the reception area outlined a plan of activities for the month including various Christmas related events. Examples included a party, craft activities and a visit from a donkey. Photos on display showed people taking part in various activities. Four activity co-ordinators were employed on a part-time basis with at least one of them being on duty each day, including weekends. Each had a speciality or area of interest.

Groups from the local community visited the service regularly. For example, on the day of the inspection the Looe Valley Singers were performing and we saw people enjoyed this with some joining in with the singing. There had also been visits from the local school when students had come in to talk or read to people. The local University of the Third Age (U3A) group regularly held meetings and groups at the service which people were able to join in with if they wished. For example, they hosted a fortnightly 'knit and natter group.' U3A is an organisation for retired and semi-retired people.

During the summer The Great Western Jazz Company performed in the garden and people enjoyed the music along with a barbecue. A mobile clothing company visited so people were able to view and purchase clothes.

We concluded the provider was now meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who wished to move into the home had their needs assessed to help ensure the service was able to meet their needs and expectations. A retired nurse had been employed specifically to fulfil this role with the support of a senior care worker. They acted as a link with families and other professionals when the person first moved in.

People had their health monitored to help ensure staff would be quickly aware if there was any decline in people's health which might necessitate a change in how their care was delivered. For example, staff checked people's skin for marks which might indicate the beginning of pressure damage developing. The checks were recorded and audited regularly so any deterioration in people's skin condition would be highlighted and the appropriate action could be taken. There was a clear traffic light system for staff to refer to which informed them of how often a person needed repositioning to protect them from the risk of developing skin damage. For example, red indicated the person needed moving every two hours. Where necessary other healthcare professionals such as tissue viability nurses were consulted. People were weighed regularly and food and fluid charts were in place to help ensure people were eating and drinking enough.

Monitoring records were kept in people's rooms so staff were able to access them easily at the point when care was delivered. This helped ensure the recordings were made in a timely manner and there was less room for errors. The records were positioned discreetly in order to protect people's privacy and confidential information.

Some people required specialist equipment to protect them from the risk of developing pressure damage to their skin. This was provided and staff had received training in how to use the equipment according to people's individual needs.

Care plans contained information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. The care plans for people who had recently moved into the service were not up to date. We discussed this with the nurse who agreed the information for one care plan; "Does not add up." The person's needs had changed rapidly and the information had become quickly out of date. There was a lack of guidance for staff. For example, it was recorded; "Has only lost mobility recently, to encourage to regain." There was no further information as to how staff were to encourage the person. There was no reference to any particular mobility aids being appropriate. We discussed this with the management team who assured us the information would be updated. Following the inspection they sent us a copy of an updated admissions care plan they were going to use for people new to the service. This would be used until such a time as staff had a clear idea of people's needs and what worked well for them when being supported by staff.

Care plans for people who had been at the service for a long time were more detailed and had been regularly reviewed. There was clear guidance for staff on the action they should take in specific circumstances. For example, one person could become agitated and distressed. There was a clear description of indicators the person might be distressed and what action staff could take to help calm them. For example, the use of music, a sensory blanket and singing a particular song. If people had specific health conditions there was clear guidance for staff on how to support them well.

Daily notes were consistently completed and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. Handovers took place between shifts and these helped staff to keep up to date with any changes in people's health needs.

People and families were provided with information on how to raise any concerns they may have. Complaints were recorded appropriately and dealt with in line with the organisational policies and procedures.

Good

Is the service well-led?

Our findings

At our last inspection in September 2015 we found the systems and processes in place to help ensure people living with dementia had their needs met were not effective.

At this inspection we found the management team worked together to regularly review the service, taking into account the needs and wishes of everyone living there. During our conversations with the management team there were repeated references to the importance of reflective practice and continually assessing people's needs. For example, staffing levels at busier times of the day had been adapted to help ensure people's needs were met. Domestic staff had been appropriately trained so they could support staff at meal times. Volunteers were also encouraged to help out. Staff supervisions and appraisals were used as an opportunity for staff to reflect on the way in which care was delivered and staff were encouraged to voice any ideas or suggestions for improvement. Staff told us things had improved since our last inspection.

We concluded the provider was now meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three registered managers who shared responsibility for the oversight of the service. They were supported by a clinical lead for the dementia unit, a compliance and quality assurance manager and a deputy matron. Each had a clear set of roles and responsibilities which were understood by staff. Some care workers had been given additional responsibilities as care ambassadors. This was in recognition of their experience and skills. There were plans in place to introduce a key worker system where named members of staff would have oversight for the delivery of care to two individuals. Relatives told us they found the service to be well organised and one commented; "[It is well organised] right from the moment you go into the reception."

One of the registered managers told us they considered Hillcrest House to be; "Very much a family home." The clinical lead commented; "It feels very wholesome." The management team were clearly passionate about delivering high quality care and helping ensure people were able to lead full and comfortable lives. This ethos and approach to care was reflected in staffs working practices.

Relatives told us they were listened to and able to approach management with any concerns. The importance of protecting family relationships was a recurrent theme throughout the inspection. Efforts were made to include families wherever possible. For example, the dementia champion had organised dementia awareness sessions for staff and was exploring the possibility of opening these up for families as well.

People, relatives and staff all told us they felt valued and cared for as individuals. People's opinions were sought out using various means including the introduction of resident ambassadors, residents meetings and review meetings.

Staff meetings were held regularly for all staff. Monthly manager meetings, meetings for domestic staff and meetings for night and day staff were organised. This meant staff had meetings which were relevant to their

roles and allowed them an opportunity to voice their opinions about how the service was run. A member of the management team told us; "Staff are more likely to speak up in small groups." An example of when staff opinion had affected how the service was run was in the use of food and fluid charts. Everyone was having their intake monitored using this method and the management team had discussed only having the charts in place for people identified as being at risk from poor nutrition or hydration. Staff had said they preferred to leave them as they were as they found them a useful tool for highlighting any trends. This had been listened to by the management and the charts had remained in use. Another idea had been put forward by a member of staff in a ROSIE feedback form. They had suggested having background music on rather than the television during meal times. Cd players and cd's had been purchased to facilitate this.

Staff told us appraisals were a particularly good opportunity for them to express any ideas. One commented; "It's a way to properly interact and be open with management. And I also got some positive feedback which is nice. A bit of input can go a long way." Another told us; "Management are very approachable. On one occasion I went to management to complain about the attitude of a member of staff, the complaint was dealt with satisfactorily."

Members of the management team attended conferences and workshops to stay abreast of any developments in the sector and keep informed of the latest guidance and research. For example, the compliance and quality assurance manager had attended a CQC inspection seminar and a compliance workshop.

Relatives were asked for their views of the service annually by means of a questionnaire. The last survey had taken place in May 2016. The results had been analysed to allow management to have an overview of the findings. Responses had been mainly positive with 93% of respondents answering 'yes' to the question; "Would you recommend the service."

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths.