Barchester Healthcare Homes Limited

Hilton Park Care Centre

Inspection report

Bottisham
Cambridge
Cambridgeshire
CB25 9BX

Tel: 01223811256
Website: www.barchester.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Hilton Park Care Centre provides accommodation and personal and nursing care for up to 93 people, some of whom were living with dementia. There are four units called Queens, Churchill, Trinity and Kings. There are external and internal communal areas for people and their visitors to use.

This unannounced inspection took place on 4 February 2016. There were 76 people receiving care at that time.

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. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were only employed after the provider had carried out comprehensive and satisfactory pre-employment checks. Staff were well trained, and well supported, by their managers. There were sufficient staff to meet people's assessed needs. Systems were in place to ensure people's safety was effectively managed. Staff were aware of the procedures for reporting concerns and of how to protect people from harm.

People received their prescribed medicines appropriately and medicines were stored safely. People's health, care and nutritional needs were effectively met. People were provided with a balanced diet and staff were aware of people's dietary needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making and applications had been made to the authorising agencies for people who needed these safeguards. Staff respected people choices and staff were aware of the key legal requirements of the MCA and DoLS.

People received care and support from staff who were kind, caring and respectful to the people they were caring for. People and their relatives had opportunities to comment on the service provided and people were involved in every day decisions about their care.

Care records were detailed and provided staff with sufficient guidance to provide consistent care to each person. Changes to people's care was kept under review to ensure the change was effective. There was a varied programme of events for people to join in with. However, not all people were supported to spend their time in meaningful ways and there were limited opportunities for some people to access the local community.

The registered manager was supported by a staff team that including registered nurses, care workers, and

ancillary staff. The service was well run and staff, including the registered manager, were approachable. People and relatives were encouraged to provide feedback on the service in various ways both formally and informally. People's views were listened to and acted on. Concerns were thoroughly investigated plans actioned to bring about improvement in the service.

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.

There were systems in place to ensure people's safety was managed effectively. Staff were aware of the actions to take to report their concerns.

People were supported to manage their prescribed medicines safely.

Staff were only employed after satisfactory pre-employment checks had been obtained. There were sufficient staff to ensure people's needs were met safely

Is the service effective?

Good

The service was effective.

Staff knew the people they cared for well and understood, and met, their needs. People received care from staff who were trained and well supported.

People's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision making process. Staff had followed the Mental Capacity Act 2005 Code of practice and the Deprivation of Liberty Safeguards.

People's health and nutritional needs were effectively met and monitored. People were provided with a balanced diet and staff were aware of people's dietary needs.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind, caring and respectful.

People and their relatives had opportunities to comment on the service provided. People were involved in every day decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

There were opportunities for people to develop hobbies and interests. However, there were limited opportunities for people who needed support to access the local community.

People's care records were detailed and provided staff with sufficient guidance to ensure consistent care to each person.

People had access to information on how to make a complaint and were confident their concerns would be acted on.

Is the service well-led?

Good

The service was well led.

The registered manager was experienced and staff were managed to provide people with safe and appropriate care.

People were encouraged to provide feedback on the service in various ways. People's comments were listened to and acted on.

The service had an effective quality assurance system that was used to drive and sustain improvement.

Hilton Park Care Centre

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 4 February 2016. It was undertaken by five inspectors.

Before our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

We asked for feedback from the commissioners of people's care and Healthwatch Cambridge .

During our inspection we spoke with 14 people, eight relatives and one visiting healthcare professional. We also spoke with the regional director, the registered manager, the deputy manager, the senior clinical nurse, three other nurses, five care workers, a chef, a domestic and a training manager. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at 13 people's care records, staff training records and other records relating to the management of the service. These included audits, rotas and meeting minutes.

Following our inspection a regular visitor to the home provided us with further feedback and the provider sent us further information about how they monitor the quality of the service people received.

Good

Is the service safe?

Our findings

People receiving the service said they felt safe. One person told us, "I feel safe here, there's always someone around." A relative said, "The care is excellent, I know [my family member] is safe here."

Staff told us they had received training to safeguard people from harm or poor care. They showed they had understood, and had knowledge of, how to recognise, report and escalate any concerns to protect people from harm. One member of staff said, "I would have no hesitation in reporting anything of concern." Staff were aware of the provider's whistle blowing policy. A staff member said, "It is part of our candour not to cover up." Staff told us they felt confident that their managers would act on any concerns they raised.

People's risks were assessed and measures were in place to minimise the risk of harm occurring. People had detailed individual risk assessments and care plans which had been reviewed and updated. Risks identified included assisting people to move, reduction of people's anxieties and for those people at an increased risk of choking. Appropriate measures were in place to support people with these risks. For example, soft food or pureed diets were available, as well as guidance on safe moving and handling techniques. Staff were aware of people's risk assessments and the actions to be taken to ensure that the risks to people were minimised.

Staff were aware of the provider's reporting procedures in relation to accidents and incidents. Accidents and incidents were recorded and acted upon. For example, where any untoward event had occurred, measures had been put in place to monitor people more frequently or check on their wellbeing more often. We saw that the potential for future recurrences had been minimised.

Staff considered ways of planning for emergencies. Each person had a recently reviewed individual evacuation plan within their care plans. This helped to ensure that appropriate support would be given in the event of an emergency, such as a fire at the service.

The staff we spoke with told us that the required checks were carried out before they started working with people. These included two written references, proof of recent photographic identity as well as their employment history and a criminal records check. This showed that there was a system in place to make sure that staff were only employed once the provider was satisfied they were safe and suitable to work with people who used the service.

Prior to our inspection a healthcare professional told us that during their recent visits they had been able to find a member of staff to support them with relative ease. Most people and their relatives felt there sufficient staff on duty to meet their needs. One person told us staff were always there for them when they need them. Another person said, "If I call or ask for help the staff help me quickly." A relative said, "There seems to be enough staff and they respond to [family members] needs very well". However, one person commented that staff often had to leave to answer call bells and another person in the same area of the home said that staff were not always gentle because they were in a hurry. Following our inspection the registered manager checked the record of how long it had taken staff to answer the call bells. They identified that in one area of the home the response times were not meeting the provider's standards, particularly during meal times.

They told us that they had taken action to address this and would monitor the situation.

Staff told us that there were sufficient staff on duty to meet the needs of the people living at service. One member of staff said, "Any [staff] absences are covered so people are not left at risk."

The registered manager told us that she used a recognised tool to assess people's needs and determine the number of staff required in each area of the service. Although the registered manager told us there were staff vacancies, we saw that the numbers of staff delivering care at any time corresponded to how many staff were required to assist people. The registered manager told us these vacancies were covered by existing permanent and agency staff. This meant there were sufficient staff to provide care safely to people.

People were satisfied with the way staff supported them to take their prescribed medicines and said they received these in a timely manner. One person said, "I always get my medicines every day." Another person told us, "I always get my medication given to me." They went on to tell us staff gave them medication for pain relief when they requested it outside of the routine times for their medicines.

We saw that people were safely supported with the administration of their medicines. Staff reminded people what their medicines were for and that they needed to take them to keep well.

There were appropriate systems in place to ensure people received their medicines safely. Staff told us that their competency for administering medicines was checked regularly. We found that medicines were stored securely and at the correct temperatures. Medicines were administered in line with the prescriber's instructions. Appropriate arrangements were in place for the recording of medicines received and administered. Where people required topical creams to be applied, there were body maps to show exactly where the individual creams should be applied. Checks of medicines and the associated records were made to help identify and resolve any discrepancies promptly.

Good

Is the service effective?

Our findings

People told us they liked the staff who worked at the service and that their care needs were met. One person said, "I am always satisfied." A relative told us, "They're [staff] on the ball and know how to deal with things." Another relative said, "The staff, are brilliant, absolutely brilliant."

The training manager explained the induction period consisted of three days classroom based learning, two days shadowing with an experienced staff member, followed by further training in a classroom. Staff confirmed that their induction, in conjunction with shadowing a more experienced member of staff had enabled them to do the job effectively. One said, "Although I had a formal induction if I needed more help I just asked without any problem."

Staff told us they were trained in the subjects deemed mandatory by the provider such as moving and handling, fire safety, safeguarding people from harm and dementia awareness. The training manager told us almost all staff had received all the required training and refresher training. They said, "The [provider expects] 85% of the staff to have all the required training, we are currently running at 96%." Staff had also had the opportunity to receive training in other areas relevant to the needs of the people they were supporting. For example, some staff told us their training included catheter care and dietary needs.

Staff who worked with people who had mental health needs told us they felt they would benefit from further training in this area. In addition, staff told us, and people's care plans confirmed, that some people could display behaviours that challenged others and may have required physical interventions and restraint. However, staff told us that they had not had training on de-escalation techniques or safe ways to restrain people. The registered manager told us they were reviewing staff member's training needs and were in the process of sourcing additional training for staff who work with people who have mental health needs.

Staff members told us they felt well supported by their managers. Staff received formal supervision regularly and said that this was a useful experience and provided an opportunity to discuss their support, development and training needs. One member of staff said, "I use my supervision time to talk about any training I think would be useful." The training manager explained that they spent time with staff to look at and discuss staff member's personal development needs so that they had the training they required.

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 to 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 found the service was working within the principles of the MCA. We saw that assessments and decisions to restrict people's liberty had been properly taken and the appropriate applications made to the relevant authority for authorisation and were reviewed three monthly. This showed that consideration had been taken to ensure the service provided was in people's best interest and was provided in the least restrictive manner.

Members of care and nursing staff were trained and knowledgeable in relation to the application of the MCA. Where people had been assessed as not having the mental capacity to make specific decisions, we saw that decisions were made in their best interest. The staff we spoke with had an understanding and were able to demonstrate that they knew about the principles of the MCA and DoLS and confirmed that any decisions made on behalf of people who lacked capacity, were made in their best interests. Records showed that the views of appropriate people had been taken into consideration. This included people who knew the person well or the person's legal representative.

Most people told us they liked the food provided. One person's relative said, "The food is good and there is always plenty, [family member] really enjoys the food and can always ask for more." Another person said, "I am never hungry because the food is so good." Another person told us the chef had accommodated their request to have the same meals every day. They told us, "I don't like variety… The cook looks after me and comes and sees me." However, four people in one area of the home said they did not like the food served. One person said, "The food is dreadful. It's not the quality of the food; it's the way it's cooked. They [staff] say you can ask for what you want. You can, but it's not good." We noted that some people in this area of the home had requested and received meals which were not on the menu.

People were offered a choice of what they would like to eat and drink in a way they could understand. Menus showed two choices available at mealtimes. In addition staff told us, and we saw, people could request other options.

People were supported to have enough to eat and drink. In addition to meals, we saw that a range of drinks and snacks were available throughout the day and night. Staff offered to help people with their meals and drinks, if they needed assistance. Efforts were made to maximise each person's independence. For example, staff made sure people had appropriate equipment to eat with and the chef told us that some people were offered additional choices that included 'finger-foods'. For example, scampi rather than steamed fish. We saw that staff gave each person the time they needed and did not try to rush them. Throughout the meal people were being asked if they wanted more to drink. There were good interactions between staff and people using the service at lunchtime in order to make it a social occasion. People could choose where they took their meals. Staff knew peoples likes and dislikes and this was recorded in their care plans

Appropriate diets were provided to people who required them and people were referred to a dietician when needed. For example, we saw that some people's diets included "nourishing drinks". This showed that people at an increased risk of malnutrition or dehydration were provided with meal options which supported their health and well-being. We noted that where people's intake of food or fluid was being monitored, the records were completed accurately. This was to help identify any change in people's food and fluid intake.

Records showed that people's health conditions were monitored regularly and that the interventions in place were having a positive impact on people's health. They also confirmed that people were supported to access the services of a range of healthcare professionals, such as the community nurses, the GP, the dietician and therapists. Staff made appropriate referrals to healthcare professionals. This meant that people were supported to maintain good health and well-being.

People were supported to access health care appointments as well as being seen by appropriate health care professionals including a speech and language therapist [SALT] or chiropodist. One person told us, "I go to hospital regularly and staff make sure I [attend] my appointment. Staff take me whenever I need to go." Another person said, "I have fallen several times and staff have called the appropriate medical people."

Good

Is the service caring?

Our findings

People and their relatives were complimentary about most of the staff. One person said, "All the [staff] are nice and they really do care for me." Another person said, "I like [name of staff] they are my favourite as they know me." However, a third person told us, "They [staff] don't try to treat me as an individual and they make me feel like a lump of meat. There is good and bad in every profession but it matters here. It can take 20 minutes to half an hour for someone [staff] to come. I get told "I'm busy downstairs" and get tutted at. There are some very good, exceptional, staff, they find the time to say good morning and take my hand. The two [staff] today make my heart lift." Another visitor told us that they had been concerned by some staff member's attitude but that this had improved over the last few weeks.

Our observations showed the staff were kind, caring and respectful to the people they were caring for. Staff called people by their preferred name and spoke in a calm and reassuring way. One relative told us that staff showed a very good understanding of people's needs. Another relative said, "[The] staff look after me as well as [my family member]."

Throughout our inspection staff maintained a caring attitude towards people. This included responding on all occasions to people's request, no matter how frequently these requests were made. We saw staff members were discreet in relation to people's personal care needs. For example, one person had fallen asleep over their drink and the care worker removed the cup and suggested quietly that they may like a fresh drink. Staff spent time throughout the day talking with people about things that were personal to them throughout the day. One visitor commented that the majority of staff speak with the person when passing the person's bedroom, which helped increase the amount of contact time they received. This showed us that staff were considerate in getting to know people and reduced the risk of social isolation.

Relatives told us that they could visit whenever they liked. A couple of relatives said they liked to visit at mealtimes to support their relative with their meals. Other visitors said they were made welcome and were treated well and provided with tea and coffee whenever they visited.

Staff knew people well and told us about people's history, health, personal care needs, religious and cultural values and preferences. This information had been incorporated into people's care plans. One visitor commented that the person they visited was happy with the religious services on offer.

Two relatives told us they had been involved in the care plans which they felt were very thorough. These provided information about people's needs and personal preferences. People were encouraged to be involved in their care planning as much as practicable. This helped staff to provide care in the way people preferred. Staff told us they encouraged people to make decisions about their day-to-day lives and people agreed with this. One person told us, "Staff give me lots of choices, and I tell them!" This showed that people were involved in decisions about their care and how it was provided.

People who required advocacy were supported in a way which best met their needs. For example, relatives and people who knew the person well were consulted and involved in best interest decisions about people's

care. Referrals had also been made for more formal advocacy, for example to an Independent Mental Capacity Advocate (IMCA) where this was required.

Relatives told us that staff respected people's privacy and dignity when supporting them. Our observations throughout our inspection showed us that staff knocked on people's doors and waited for a response before entering. They also let people know who they were as they entered. This meant that staff respected and promoted people's privacy.

People had their own bedrooms and staff had supported people to personalise their bedrooms with photographs and small items of furniture. We saw that people had brought in their own furniture and that rooms were personalised with pictures, photos and paintings. This was to help people orientate themselves as well as being personal to them.

People were kept informed of changes to the service. For example, we saw that people had received letters telling them about the change of manager at the service.

Good

Is the service responsive?

Our findings

People and relatives felt that staff understood and responded to people's needs. One relative told us, "The staff really look after [my family member] and give them all the care and attention. I could not ask for better."

People's care needs were assessed prior to them moving to the service. This helped to ensure staff could meet people's needs. This included people's life history, preferences, allergies, friends and their hobbies and interests. This assessment formed the basis of people's care plans and was to help ensure that the care that was provided would effectively and consistently meet people's needs. For example, there were clear instructions as to how to care for a person who was fed via a percutaneous endoscopic gastrostomy (PEG). This included how to care for the site and how their medication should be managed via the tube. Care plans also included people's preferences. For example, people's preferred time for getting up as well as any preference for male or female staff that people may have had. One person told us, "I like it here at [name of service] as I get to do the things I like such as [name of pastime]."

Staff told us they enjoyed their roles. One staff member said, "I love working here we always put people who live here first. [People] receive person centred care and [the staff] all work well together". We found that staff were knowledgeable about people's needs and preferences and that people's care and health care needs were being met. Daily care notes confirmed this. For example, there was a clear record of when routine procedures such as wound dressings or urinary catheter changes were changed. Staff told us they completed the daily notes as soon as possible after providing care. These had been written in detail and clearly described the care and support provided to a person.

People's care plans were reviewed regularly and reflected people's changing needs. Staff recognised if people were unhappy or not their usual selves. Examples included changes in people's mood as well as people telling staff about any concerns they may have had. Staff knew how to respond to people in those situations as well as having the right steps in place to ensure all staff maintained a consistent approach to people's individual care needs.

The layout of the unit was suitable for people with nursing needs. One relative said they had been concerned their family member was away from the main nurses' desk. However, they said they were assured that staff did provide satisfactory care and had introduced a communication book to use if the relative did not see staff. The relative told us, "When [my family member] was in hospital I felt I had to visit every day. I now feel I can have some time off and [my family member] will be looked after."

Adaptations had been made to ensure the service was a safe place to live, especially for people with mental health conditions or reduced cognitive function. These included wheelchair access to all areas as well as the space for people to go outside when they wished.

The provider employed activities co-ordinators who had put together a varied programme of events for people to join in with. However, there were limited opportunities for some people to access the local

community. Some people told us staff encouraged and supported them with various planned events and activities which had included a Chinese food sampling, sing-a-longs and an exercise class. Other sessions included music sessions, aromatherapy, poems and well know singers which people shared an affinity with. People were given the choice to attend and where appropriate encouragement was offered to any person who needed this to help maintain their well-being. One person said, "I am always getting a knock on my door about some activity or another. They keep our brains ticking over." Another person said, "I love living here as I can do the things I like, singing and playing my guitar." A third person said, "The activities are quite good. We have a list of the weekly activities… They do manicures [and] we also have a good hairdresser. I walk over to the other units to get some fresh air and talk to people. We have someone who goes shopping once a week and they will buy anything I need, but I miss retail therapy. There is a church or communion service once a month."

In one area of the home we saw that people were not supported to engage in activities or past-times during the morning of our inspection. We saw that although there was some staff interaction and conversation, most people spent their time just sitting in the dining room.

Staff told us that they had limited spare time to encourage people to engage in hobbies and interests. In addition, where people who lacked mental capacity to make specific decisions and were being deprived of their liberty and needed to be supervised whenever they were out, there were limited opportunities for people to access the local community. This meant that people were not always supported with their day to day hobbies, social interests and access to the community. We discussed this with the registered manager who told us this was under review.

People and their relatives said that staff listened to them and that they knew who to speak to if they had any concerns. Everyone we spoke with was confident the registered manager or another member of staff would listen to them and address any issues they raised. One person commented, "I have nothing to complain about but I would tell [the registered manager]." Another person told us, "I'd go straight to management, if they don't know [what's wrong] they can't put it right." A relative said, "I have no complaints and would tell the staff." Another relative told us, "I have no complaints but I know who to speak to if I have."

Information about how people could complain, make suggestions or raise concerns was available throughout the service. This was also in an appropriate format if people preferred to express their wishes in a different way. Staff had a good working understanding of how to refer complaints to senior managers for them to address.

Good

Is the service well-led?

Our findings

We received positive comments about the management of the service from the people, visitors and staff. One person told us "We have a new manager who seems very nice and open to discussion to improve the service." Another said, "[The registered manager] has only been here a month but she has been to my room for a chat for a few minutes." A relative said, "I have found the manager to be very approachable and willing to listen."

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 manager was supported by a staff team that included registered nurses, care workers and ancillary staff. Staff were clear about the reporting structure in the service. From discussion and observations we found the staff had a good knowledge and understanding of the care needs and preferences of the people receiving this service.

The registered manager was approachable and a staff member said, "It is much better now we have a manager who isn't office bound." Another said, "[The registered manager's] door is always open." There was an open and honest staff culture which was being further fostered by the registered manager. Staff told us that they had regular supervision, support and also training according to their role. A staff member said, "Although the manager is new I already feel she is supportive."

Staff we spoke with had a shared understanding of the values of the provider. This included putting people first and foremost in everything related to living at the service. One staff member told us, "It's lovely working here. People greet me at the door. [The registered manager] and [the deputy manager] are really supportive managers. I can ask them anything and they always know how to help." Another said, "[The registered manager] is a very approachable person." We saw that the staff worked as a team and that a good staff team culture existed. Staff told us that they helped each other and that they enjoyed working at the service. One said, "The reason I like [working] here is the difference I make, each day, to people's lives. It can be as simple as seeing people smile."

All the staff we spoke with were familiar with the procedures available to report any concerns within the organisation. They all told us that they felt confident about reporting any concerns or poor practice to more senior staff including the registered manager. Staff all said that the manager was approachable and had an open door policy. All said they could speak freely at meetings and during supervision even before the new manager came into post. We saw that following concerns having been raised, action plans had been developed, followed and monitored. This had helped bring about improvement in the service.

The registered manager sought feedback from people in various ways. One person said, "The [registered] manager encourages us to let them know our views." Another person commented, "The staff are always asking how I am and if there is anything I want to change." The senior team hosted regular meetings for people and relatives to put forward their views. Minutes showed various issues were discussed and

actioned. For example, people requested events included classical music and exercise classes. We saw both of these were included in the events programme. These meetings were also used for sharing information, such as introducing the new registered manager.

The quality of people's care and the service provided had been monitored in various ways. This included senior staff regularly carrying out spot checks of staff member's work. The registered manager and the staff stressed throughout our inspection the importance of spending time with the people who receive the service and the staff who provide it. The Clinical Lead Nurse told us they worked alongside staff on shifts. This helped the provider to ensure that staff were working to the expected standard was well as being able to mentor staff in their role.

We saw that meetings of various staff groups took place. For example, meetings for staff who work during the night, staff that work on each of the units and heads of department. Minutes showed a variety of issues raised and included managers cascading information and staff raising issues that concerned them.

The regional director conducted regular audits and agreed an action plan with the registered manager of any areas for improvement. They said this was monitored by senior managers and any extensions to action dates had to be agreed with them.

Records we held about the service, records we looked at during our inspection and our discussions with the registered manager confirmed that notifications had been sent to the CQC as required. A notification is information about important events that the provider is required by law to notify us about. This showed us that the registered manager had an understanding of their role and responsibilities.