

European Healthcare Operations Limited

Hill Ash House

Inspection report

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Ratings

Overall rating for this service

Good



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Good



Overall summary

The inspection took place on the 9 and 11 June 2015 and was unannounced.

Hill Ash House is a care home for up to 36 people, located in the village of Dymock. At the time of our inspection there were 27 people living at the home.

Hill Ash House had a registered manager. 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.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report

Some aspects of the management of people's medicines around storage and transcription checks were unsafe.

Summary of findings

People were not protected from the risk of being cared for by unsuitable staff because robust recruitment practices were not consistently operated.

People were supported by sufficient numbers of staff who received appropriate training and had the right knowledge and skills to carry out their role. People were protected from the risk of abuse by staff who understood safeguarding procedures.

People were supported by staff with the knowledge and skills to carry out their roles, including knowledge of the Mental Capacity Act 2005.

People received support from caring staff who respected their privacy, dignity and the importance of independence. People received personalised care and there were arrangements in place for people and their representatives to raise concerns about the service.

The manager was accessible and open to communication with people using the service and their representatives. Quality assurance checks on the service including the views of people using the service and stakeholders had been completed as a way of ensuring the quality of the service provided.

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?

The service was not fully safe.

Medicines were not always stored correctly and checks had not been made on the accuracy of hand written directions for people's medicine.

People were not protected from the risk of the appointment of unsuitable staff because robust recruitment practices were not operated.

People were protected from the risk of abuse because staff understood how to protect them.

Risks to people relating to their care and from the environment were assessed and monitored.

Requires improvement



Is the service effective?

The service was effective.

People were supported by staff who had the knowledge and skills to carry out their roles.

People's rights were protected by staff's knowledge of the Mental Capacity Act (2005).

People were consulted about meal preferences and supported to eat a balanced diet.

People's health care needs were met through on-going support and liaison with healthcare professionals.

Good



Is the service caring?

The service was caring.

People were treated with respect and kindness.

People and their representatives were consulted about the care provided to meet their needs.

People's privacy, dignity and independence was understood, promoted and respected by staff.

Good



Is the service responsive?

The service was responsive.

People received individualised care and were supported to take part in a choice of activities.

People were enabled to engage in activities in the home and the community.

Good



Summary of findings

There were arrangements to respond to any concerns and complaints by people using the service or their representatives.

Is the service well-led?

The service was well led.

The vision and values of the service were clearly communicated to staff.

The manager was accessible and open to communication with people using the service and their representatives.

Quality assurance systems were in place to monitor the quality of care and safety of the home.

Good



Hill Ash 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.

This inspection took place on 9 and 11 June 2015 and was unannounced. Our inspection was carried out by one inspector. We spoke with three people who used the service and two visiting relatives. We also spoke with the registered manager, the head of care, the administrator and four members of care staff. We carried out a tour of the

premises, and reviewed records for four people using the service. We also looked at seven staff recruitment files. We checked the medicine administration records (MAR) and medicine storage arrangements for people using the service.

Before the inspection, the provider completed a provider information return (PIR). The PIR 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. Before the inspection we looked at notifications the service sent to us. Services tell us about important events relating to the service they provide using a notification.

Before our inspection we received information from a health care professional and a social care professional who had been involved with people using the service.

Is the service safe?

Our findings

People's medicines were stored securely and storage temperatures were monitored and recorded. However we found that temperatures for the medicine trolley had been recorded as higher than the correct limit on the first day of our inspection and on eight occasions in May 2015. Records showed that storage temperatures for the medicine trolley had been too high on eight occasions in August 2014. Remedial action had been taken by using a fan although this had not been completely successful at lowering the temperature to within correct limits. An audit by the supplying pharmacist in 2014 had highlighted the issue with high storage temperatures. If medicines are not stored properly they may not work in the way they were intended and so pose a potential risk to the health and wellbeing of the person receiving the medicine.

People's medicine records were not always managed safely. Hand written directions for giving people's medicine had been written on the current medicines administration record (MAR) by staff. These included antibiotics and medicines for pain relief. However there was no signature for the staff who entered the directions on the administration chart and a second member of staff had not signed these directions to indicate they were checked and correct. One of the medicines checks detailed for week one of the monthly medication audit was for two staff to sign any hand written entries on the medicine charts. Not following this process could result in errors in how people are given their medicines.

We found that the registered person had not protected people against the unsafe use and management of medicines. **This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff responsible for administering medicines had received training and had passed competency assessments. Individual protocols were in place for medicines prescribed to be given as necessary. There were records of medicines being received into the home and being disposed of when required.

People were at risk of being cared for by unsuitable staff because robust staff recruitment procedures were not being used. One member of staff had not given their reasons for leaving a previous employment which involved

work with vulnerable adults. Their conduct in this employment and their reasons for leaving had not been checked as part of the recruitment process. For another member of staff, information had been obtained about a previous job in care from a person who was not a manager of the care service. Therefore they would not have been in a position to share relevant information about the person's conduct. The registered provider's recruitment policy did not reflect the regulations relating to employment checks for staff previously working with vulnerable adults. We discussed our findings with the registered manager who had contacted the registered provider's human resources department to rectify this.

Disclosure and barring service (DBS) checks had been carried out before staff started work. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

We heard mixed views about the levels of staffing at the home from people, their relatives and staff. One person told us there were enough staff to meet their needs, another commented "they manage to cope". Some staff felt that staffing levels should increase as occupancy rose. The registered manager explained how the staffing was arranged to meet the needs of people using the service and how the assessment of needs of anyone looking to move into the home played a part in this. The PIR stated "Establishment staffing levels are maintained on a daily basis to reflect the needs of individual residents and additional staffing are engaged as necessary." During our inspection we observed that staff responded to people's needs in a timely manner. One person told us "If I ring the bell they come."

People were protected from abuse by staff with the knowledge and understanding of safeguarding policies and procedures. People we spoke with told us they felt safe living at Hill Ash House. Information given to us at the inspection showed all but the most recently recruited staff had received training in safeguarding adults. The next safeguarding training session was planned for June 2015. Safeguarding training was updated annually. Staff were able to describe different types of abuse and the arrangements for reporting any allegations of abuse relating to people using the service. They also knew where in the care home they could find information about protecting people from abuse. One member of staff stated

Is the service safe?

they felt confident any safeguarding concerns would be dealt with if reported to management. People using the service said they felt safe living at Hill Ash House. People were protected from financial abuse because there were appropriate systems in place to help people manage their money safely.

People had individual risk assessments in place. For example there were risk assessments for pressure area care, falls and nutrition. These identified the potential risks to each person and described the measures in place to manage and minimise these risks. Risk assessments had been reviewed on a regular basis. People's safety in relation to the premises and equipment had been managed with

action taken to minimise risks from such hazards as legionella, fire and electrical faults. Personal fire evacuation plans were in place for people using the service should they need to leave the building in an emergency.

People were protected from risk of infection through action taken following audits in line with national guidelines on infection control. Staff had received training in infection control in 2014 with dates booked for 2015 for the annual renewal of the training. The cleanliness of the premises had been maintained and an inspection of food hygiene by the local authority in 2014 had resulted in the highest score possible.

Is the service effective?

Our findings

People using the service were supported by staff who had received training for their role. People told us that staff knew what they were doing when giving care and support. People made positive comments about staff such as “very good” and “staff are extremely nice and very helpful”. Staff had received training in such areas as moving and handling, equality and diversity, food hygiene, dementia awareness and first aid. They had also achieved nationally recognised vocational qualifications in social care. We saw training certificates in staff member’s individual files. They told us they felt the training provided by the service was enough for their role. One member of staff commented on the “very supportive environment” since starting work at Hill Ash House. Another told us, “we have good training” and added “our training has to be kept up to date”. Information given to us at the inspection visit confirmed the training that staff had received. Induction training in line with national standards had been completed by one member of staff. In addition the registered manager had an awareness of the new Care Certificate qualification. Staff had regular individual meetings called supervision sessions with the manager or a senior member of staff.

People’s consent to care and treatment was sought appropriately and this was supported by the correct use of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make certain decisions for themselves. The DoLS protect people in care homes from inappropriate or unnecessary restrictions on their freedom. The registered manager was aware of the up to date legislation regarding protecting the liberty of people in care homes. An application had been made to restrict the liberty of one person using the service and a decision was still awaited for this. Staff demonstrated an understanding of

the principals of the MCA such as specific decisions being made in people’s best interests where an assessment showed they lacked mental capacity. We saw an example of a ‘Do not attempt resuscitation’ order for one person. This had been completed by a GP and recorded consultation with a relative and other care professionals due to the person lacking mental capacity.

People had a choice of two main courses for lunch on a daily basis. One person told us the lunch was “fine” and were looking forward to their dessert. The menu changed seasonally and when we visited the summer menu was in use. Information was displayed in the home about the availability of snacks and drinks for people at any time of the day or night. The registered manager told us the creation of a servery adjoining the dining area enabled night staff to prepare snacks for people more easily. We observed people taking lunch in the dining area. A calm atmosphere was maintained with attentive staff under the direction of the chef offering choices of drinks and serving people their chosen meals. Some people had taken advantage of the good weather and were taking their lunch at tables in the adjoining courtyard. Where people required assistance with eating and drinking this was provided in a discreet and sensitive way. Feedback about meals from residents at their May 2015 meeting was positive and demonstrated that people were appreciating the choices on offer.

People’s healthcare needs were met through regular healthcare appointments. People told us how they were visited by a GP if needed. One person told us “If I ask to see a doctor they would get one for me, they would know if I needed a doctor or not.” People also received input from district nurses, and chiropodists. Records were kept of visits by health professionals. Where necessary people had support plans for specific long term or short term health care needs.

Is the service caring?

Our findings

People told us staff treated them with kindness. One person using the service told us “I am well looked after”. People told us staff were “thoughtful and polite” and “friendly and very kind”. One relative said “the care is superb” and commented staff were “very caring”. Minutes from recent residents’ meeting contained praise from people about the care staff gave to them. During our observation at lunchtime we noted staff speaking to people to check on their wellbeing as well as attending to their needs with eating and drinking. Staff were attentive and respectful to people. Staff paid attention to detail with people’s needs such as ensuring people were able to wipe their hands before lunch was served to them.

People told us they had been consulted about plans for their care. During our inspection the registered manager was consulted by visitors about their relatives care and support needs. People told us how they attended resident’s meetings to give their views on the service and recorded minutes supported this. Meetings were held on a monthly basis. People were consulted about their views on staff, menus, activities and the care they received.

Information about local advocacy services was available at the home, the registered manager had knowledge of where the use of such services may be appropriate. At the time of our inspection a situation had arisen where a person had been referred to an advocacy service to determine if support could be provided around a specific issue.

People’s privacy and dignity was respected. People told us staff knocked on the doors of their rooms before entering and this was the practice we observed during our inspection. Staff gave us examples of how they would respect people’s privacy and dignity when providing care and support such as ensuring doors were closed and people were adequately covered when providing personal care. Care plans for personal care reflected people’s preferences as to the gender of staff they received care from. People’s preferred names were recorded for staff to address them in line with their wishes. In a recent development, the home was looking at appointing a dignity champion as part of a national scheme to promote the dignity of people receiving care and support. People’s plans for the end of their life had been discussed with them and/or their representatives as appropriate and recorded where people felt able to do this.

People were supported to maintain independence. Staff gave us examples of how they would act to promote independence such as giving prompts to people to maintain personal care tasks. This approach was reflected in one person’s care plan which included specific actions for staff to take to support a person with their personal care. As we toured the home we observed a member of staff supporting a person to mobilise independently, they offered encouragement as well as adopting an unhurried approach telling the person to “take your time”.

Is the service responsive?

Our findings

People received personalised care and support. We saw how the service had responded to meet the individual needs of people and listened to their views and wishes. Care plans were personalised with specific and individualised information about people's care needs and the actions for staff to take to meet them. One person told us how they had been provided with a water bottle suitable for their needs which they could keep with them to ensure they were able to take adequate fluids. They had raised the issue at a recent resident's meeting. One member of staff we spoke with was particularly passionate about people receiving care personalised to their needs, explaining the importance of offering people choice. Care plans had been kept under review with a system of reviewing one resident's care plans each day. This resulted in each person receiving a monthly review of their care plans.

Suitable adaptations had been provided in the bedrooms of people with sensory impairment such as flashing light door 'bells' and vibrating devices to alert them in the event of fire. People kept in regular touch with a local support organisation for people with sensory impairment by being taken to monthly lunches. Contacts had been long established with the support organisation to act as a resource to help support people in the home with their specific needs. One person with a sensory impairment did not use a specific form of communication. Their care plan contained detailed information to help staff understand the person's needs and to communicate with them.

A recent development was the introduction of a single sheet version of care plans presented on a laminated sheet. These provided an 'at a glance' format for important individual information about people, useful to agency staff and new staff. Information included was critical care needs

and sections on "what I like to be called" and "tips for talking to me". A system of supplementary care plans was also under development. This enabled information about critical care needs such as people's weight or skin integrity to be highlighted in a clinical risk register for preventative measures to be taken where needed.

People were supported to take part in activities. A range of activities were held in the home including bingo, baking, crafts and visits from entertainers. On the second day of our inspection visit people were occupied by various small exotic animals visiting the home along with a handler. People also took part in gardening and people we spoke with were pleased to tell us about tomato plants they had been involved in planting and tending in the courtyard. Outings were also organised and had included a recent trip on a canal boat. Various activities were being developed suitable for the needs of people living with dementia some involving the use of poetry to stimulate people's memory.

There were arrangements to respond to any concerns or complaints. Complaints were recorded, investigated and responses provided to complainants. We looked at two complaints received from representatives of people using the service, all correspondence relating to the complaints had been retained and appropriate responses had been given. The complaints procedure was displayed on notice boards throughout the home. The registered manager described the improvements made to the expectations and arrangements around visits by health care professionals following a complaint in 2014. We spoke with a visitor who told us they had raised issues about their relative's, eye sight, and the following week an eye test had been arranged for the person. On the day we spoke with them they were concerned their relative had missed a chiropody appointment. They were confident this would be dealt with by the time they next visited.

Is the service well-led?

Our findings

The registered manager told us their vision was to achieve a service with a focus on what the residents wanted as opposed to being task driven. Aspects of this approach had been shared with staff at meetings where discussions included care and support at night and the importance of helping people get ready for bed at the time of their request. The registered manager was visible and accessible to people using the service, staff and visitors and therefore was aware of events at the care home. During our inspection visit, we observed people and their representatives freely approaching the manager in their office. One person using the service told us “you can always speak to the manager if you want to”. Staff told us the registered manager was “very approachable”. A health care professional also commented “The manager is very approachable.” In the interests of developing the openness of the service, links had been established with the local community. These included links through visits to lunches and coffee mornings at a local church community centre, membership and attending a book club at the local library and attending groups in the community for people living with dementia.

Staff demonstrated a clear awareness and understanding of whistleblowing procedures within the provider’s organisation and in certain situations where outside agencies should be contacted with concerns. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

The home had a registered manager who had been registered as manager of Hill Ash House since March 2015. The manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. Information about notifying us

about these events was displayed in the manager’s office. We had been promptly notified of these events when they occurred. Although there was a vacancy for a deputy manager, the registered manager received support from the head of care and a senior team leader. Minutes of staff meetings demonstrated that staff were kept informed about developments in the service. Both care and general staff meetings included information and discussions about planned maintenance work, ideas for activities and links with the local community. People and their representatives were positive about the management of Hill Ash House. One person told us the management was “very good”. Staff were also positive with one commenting, “I think it is well-run”.

People benefitted from audits completed for various aspects of the service provided. Audits resulted in action plans where areas had been identified for improvement. An audit of meals provided had resulted in the choice of two main courses at lunchtime and increased availability of snacks. Audits had also been completed on documentation, care and the facilities of the care home. As well as audits action plans were created from points raised at residents’ meetings. Issues raised at the May 2015 meeting had resulted in improved access to drinking water and moves to purchase a new stand aid hoist. The views of people using the service and their representatives had been sought through annual questionnaires. Views were sought on such aspects of the service as the way staff spoke to people, people’s spiritual needs and the cleanliness of rooms. Suggestions for improvements were also requested in the questionnaires. Responses were collected, reviewed and relevant points included in an action plan. Quality was also checked through regular visits to the care home by representatives of the registered provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Appropriate arrangements were not in place to protect people against the unsafe use and management of medicines.