Four Seasons (Bamford) Limited

Hill View Care Home

Inspection report

Hurst Lane (Off Crankshaw Street)
Rawtenstall
Rossendale
Lancashire
BB4 7RA
Tel: 01706218484
Website:

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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

Overall summary

We carried out an inspection of Hill View on 10 and 11 December 2014. The first day was unannounced. We last inspected Hill View to carry out a responsive review on 13 March 2014 to look at safeguarding issues and found the service was meeting the current regulations in the outcome assessed.

The home is a 46 people bedded care and nursing home registered to provide personal or nursing care to older people. Accommodation is provided in single rooms two of which have en-suite facilities. At time of the inspection there were 36 people accommodated in the home.

The home was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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

There was evidence that the rights of each person to take control over their own lives and make their own decisions and choices was at the heart of their care. People told us they felt safe. They said they had never had any concerns about how they or other people were treated. Staff were described as being 'very good'. People identified as having some difficulty making choices were supported for example by a relative.

People told us they were cared for very well. They also considered their privacy and dignity was respected. There were two appointed 'dignity champions' in the staff group.

We found staff were attentive to people's needs. They understood the varying needs of the different people we had discussed with them. Staff said they enjoyed their work and worked well together. There was a stable staff team who were clear about their responsibilities and duty of care.

People had their medication when they needed it. Medicines were managed safely. We found accurate records and appropriate processes were in place for the ordering, receipt, storage, administration and disposal of medicines.

The home was warm, clean and comfortable and people were satisfied with their bedrooms and living arrangements. Cleaning schedules were followed and staff were provided with essential protective clothing. There were contractual arrangements for the disposal of clinical and sanitary waste and the water supply was monitored for the control of Legionella. Water temperatures at source were maintained at a safe temperature to prevent accidental scalding.

A variety of activities were provided. The activity co-ordinator also engaged with people who preferred to or benefitted from having one to one activity sessions. Personal journals were being completed regarding activities and visiting arrangements were good.

People were cared for by staff that had been recruited safely. Staff had relevant training to support them in their role and in response to people's changing needs. They were kept up to date with changes in people's needs and circumstances. People were cared for by staff who were trained well and were supervised.

We saw that referrals had been made to the relevant health professionals for advice and support when people's needs had changed. People who may be at risk of falling, developing pressure ulcers, or may not eat enough were identified and action had been taken to minimise the risk.

People's lifestyle was centred on them and they did not have to conform to any institutional practice such as set times for getting up or going to bed. Meals provided met with their tastes, needs and choices. Routines were seen to be flexible to accommodate people's varying needs.

People told us they were encouraged and supported to express their wishes and opinions. There were opportunities for people to give feedback about the service in quality assurance surveys. Recent surveys showed overall satisfaction with the service. People told us they knew how to make a complaint and felt confident any issue they raised would be dealt with promptly.

We were told by staff, visitors and people using the service the management of the service was good. There were processes in place to support the registered manager to account for the actions, behaviours and the performance of staff. The registered manager was also monitored by the regional manager who visited the service on a monthly basis as part of the provider's quality monitoring. Checks were made to make sure the registered manager was meeting the required company standards in the day to day running of the home.

Senior staff had taken lead roles, for example in medication, fire safety, health and safety and infection control. This meant they kept up to date with best practice issues

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?

Good

The service was safe. People told us they felt safe. Staff had a good understanding of what constituted abuse and were confident to report any abusive or neglectful practice they witnessed or suspected.

The home had sufficient skilled staff to look after people properly. During our visit we observed staff in attendance in all areas of the home and people's calls for assistance were promptly responded to.

People had their medication when they needed it. Appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. The home was clean and hygienic.

Is the service effective?

Good

The service was effective. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate action was taken to make sure people's rights were protected. Decisions made took into account people's views and values.

Staff were supervised on a daily basis. All staff received a range of appropriate training and support to give them the necessary skills and knowledge to help them look after people properly and support people's changing needs.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Food served was nutritious and plentiful and people told us they enjoyed their meals.

Is the service caring?

Good

The service was caring. People we spoke with and relatives visiting told us they found the staff to be very caring.

We found staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care. Where people required one to one support such as with eating and personal care this was given in a dignified manner.

Two staff members had been appointed dignity champions for the service.

Is the service responsive?

Good

The service was responsive. People were given choices on how their care was given. People received care and support which was personalised and responsive to their needs. People knew how to make a complaint and felt confident any issue they raised would be dealt with promptly.

People were given additional support when they required this. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed.

There were opportunities for involvement in regular activities. People were involved in discussions and decisions about the activities they would prefer which helped make sure activities were tailored to each person.

Summary of findings

Is the service well-led?

Good

The service was well led. The registered manager monitored people's care and support. There were effective systems in place to seek people's views and opinions about the running of the home. This was supported by a variety of systems and methods to assess and monitor the quality of the service.

The quality of the service was monitored and by a regional manager who visited the home on a regular basis and conducted a full assessment of staffing, people's care and the environment.

Hill View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 11 and 12 December 2014 and the first day was unannounced.

The inspection team consisted of a lead inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also had contact with representatives from the local authority social work and safeguarding teams, who provided us with feedback about the service. We reviewed information we currently held about the service that included notifications we had received prior to our visit.

We spoke with ten people living at Hill View, two relatives, five care staff, one care co-ordinator, a cook and two domestic and laundry staff, the regional manager, one registered nurse and two visiting health care professionals. We observed care and support in communal areas and also looked around the premises and in some people's bedrooms.

We looked at a sample of records including three people's care plans and other associated documentation, recruitment and staff records, medication records, policies and procedures, complaints records, quality monitoring surveys and audits and staff and management meetings.

Good

Is the service safe?

Our findings

We spoke with 10 people using the service and with two relatives who told us they were regular visitors to the home. We asked people living in the home and visitors if they had ever experienced or witnessed any behaviour or attitude by staff that had given them cause for concern. One person told us, "I can speak up for myself and I do. Having said that I know others can't be as vocal but from what I've seen staff are very good with people." Another person told us, "I think they are all very kind. I get all the help I need without any fuss or bossiness." One relative said, "I can only speak from my experience in visiting. They have been marvellous with my wife and look after her exceptionally well. They are very patient with her and considerate to me." People living in the home told us they felt safe and were looked after very well. They had nothing to worry about and staff were described in terms of being "grand", "good" and "very nice."

People using the service and relatives told us there were no institutional practices imposed such as what time people went to bed or got up in the morning. All routines were flexible enough to accommodate this. People were observed to be comfortable around staff and did not show any signs of distress when staff approached them. We observed staff used safe ways of working, for example, when they assisted people to mobilise.

We looked at three staff recruitment files and spoke with two staff members who had recently been recruited about their experiences of the recruitment and induction process. They told us they had completed an induction training programme and had shadowed more experienced staff when they started. They were given support and supervision, and were currently doing training. Staff records were organised and we found completed application forms, references received and evidence the Disclosure and Barring Service (DBS) were completed for applicants prior to them working. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This check helps employers make safer recruitment decisions. Good disciplinary procedures were in place to support managers take the appropriate action to deal with any staff member who were found to be in breach of their contractual arrangements.

We looked at the staffing rotas. We found the home had sufficient skilled nursing, care and ancillary staff to meet people's needs. The regional manager told us any shortfalls, due to sickness or leave, were covered by existing staff and it was rare they used agency staff. A relative said, "There is always staff around when I visit." Another relative told us, "I think there is enough staff. My wife is always dressed very nice, clean and comfortable." During our visit we observed staff in attendance in all areas of the home and people's calls for assistance were promptly responded to.

We discussed safeguarding procedures with staff. They were clear about what to do if they had any concerns and indicated they would have no hesitation in informing the registered manager if needed. Staff were confidently able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. There were policies and procedures in place for their reference including whistle blowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. There was guidance displayed informing people about abuse and who to inform if they suspected abuse was taking place. Staff training records showed all staff had been trained in safeguarding vulnerable adults.

We were able to establish risk assessments linked to peoples' welfare and safety had been completed and the management of known risk planned for. People who may be at risk of falling, developing pressure ulcers, or may not eat enough were identified. However we found that one person at risk of poor nutrition did not have a care plan to describe the support offered to them. We discussed this with the person in charge as without formal guidance, people may be at risk of being malnourished. The person in charge rectified this straight away and gave us reassurance everything possible was being done to support this person.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. Arrangements were in place for confirming people's current medicines on admission to the home. Medication was delivered pre packed with corresponding Medication Administration Records (MAR) sheets for staff to use. We looked at MAR sheets and noted safe procedures were followed where hand written records of medication were used. We found that where new medicines were prescribed, these were promptly started and that sufficient stocks were maintained to allow continuity of treatment.

Good

Is the service safe?

This was for example when people had been admitted from hospital. We saw that people requiring urgent medication such as antibiotics received them promptly. Arrangements with the supplying pharmacy to deal with medication requirements were good and medicines were disposed of appropriately. All records seen were well maintained, complete and up to date and we saw evidence to demonstrate the medication systems were checked and audited on a regular basis.

Appropriate arrangements were in place for the management of controlled drugs. These are medicines which may be at risk of misuse and require extra monitoring. Controlled drugs were stored appropriately and recorded in a separate register. We checked five people's controlled drugs and found they corresponded accurately with the register. Care records showed people had consented to their medication being managed by the service on admission. Where medicines were prescribed 'when required' or medicines with a 'variable' dose, guidance was recorded to make sure these medicines were offered consistently by staff as good practice. Medicines required at different times during the day were managed well. Training records showed all staff designated to administer medication had completed training. Staff confirmed this. We checked the policies and procedures relating to medication and found these reflected good practice.

We checked the arrangements for keeping the home clean and hygienic. There were two domestic staff and a laundry staff on duty at the time of our visit. We discussed cleaning arrangements with a domestic staff. They told us they had a cleaning schedule they completed on a daily, weekly and monthly basis. We found the home to be clean and hygienic. All of the toilets and bathrooms and bedrooms we checked were clean.

There were policies and procedures in place for the control of infection and infection control audits were undertaken regularly. Environmental health had awarded the service with a maximum of five star rating for food hygiene. Staff were provided with personal protective equipment such as disposable gloves and aprons. There were contractual arrangements for the disposal of clinical and sanitary waste. The water supply was monitored for the control of Legionella and water temperatures checked to monitor water at source was at a safe temperature for people using the service. Fire detection systems were tested regularly and building evacuation plans in place.

Security to the premises was good and visitors were required to sign in and out. We were also shown health and safety monitoring that was being followed as routine such as, safety of the premises, furniture, fittings and equipment used.

Is the service effective?

Our findings

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. During our visit we observed people being offered choices and consenting to care and treatment. Staff we spoke with were aware of people's capacity to make safe decisions and choices for themselves. We found they had an understanding of the principles of these safeguards and training records showed all staff had received training on the topic.

Care records showed people's mental capacity to make decisions for themselves had been assessed and useful information about their preferences and choices was recorded to help staff to support them as they wished. There was evidence to show appropriate action had been taken to apply for DoLS authorisations in accordance with the MCA code of practice. One person was currently supported with a DoLS authorisation and had a care plan in place to make sure their wishes were considered and taken into account when applying this.

Records showed there was an induction programme for new staff which would help make sure they were confident, safe and competent. This included a review of policies and procedures, initial training to support them with their role and shadowing experienced staff to allow them to develop their role.

Staff spoken with had a good understanding of their role and responsibilities and of standards expected from the registered manager and provider. We discussed training opportunities with them. They told us they were given opportunities and time to attend training. We looked at the staff training record. This showed us staff were given and had completed extensive training and was mainly by e-learning. The regional manager told us this was monitored electronically and some topics were followed by practical training and or a written assessment. Training included for example, moving and handling, fire safety, first aid, health and safety, safeguarding, the MCA 2005 and DoLS. We spoke with a new staff member. They told us they had induction training when they started work and worked alongside more experienced staff.

The person in charge told us eight people had 'Do Not Attempt Resuscitation' (DNAR) consent forms in place. We looked at three completed DNAR's and found these had been authorised during people's stay in hospital and were indefinite. These had been kept under review at the home. There was no evidence any discussion had taken place with relatives or the people the DNAR related to, or evidence the GP's were part of the review. We discussed this with the regional manager as one persons' review was clear their wish was for family involvement with decisions about their care. This meant relatives and GP's did not necessarily know of their existence. It is essential that the General Medical Council's code of conduct and practice is followed when DNAR's are put in place. The regional manager acknowledged our concerns and assured us this would be given priority and dealt with. We were shown audits that had recently been carried out that had identified issues around DNAR. The nurse on duty immediately contacted relatives and GP's and arrangements were made for the DNAR to be reviewed with all parties present.

We looked at pre admission assessments for three people. We found information recorded supported a judgement as to whether the service could effectively meet people's needs. People had a contract outlining the terms and conditions of residence that protected their legal rights.

We looked at measures the provider had taken to make sure people were supported to have adequate nutrition and hydration. Care records included information about the risks associated with people's nutritional needs. We saw for example staff were instructed to weigh people and report any loss in weight or problems people had. People at risk were monitored and food and fluid intake charts were maintained. We also saw people's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed. We noted in one instance whilst risk assessments were in place to support one persons' particular nutritional needs, they were reported to have difficulty eating and had lost weight. We had observed the persons food taken away uneaten at lunch time. We discussed this with the regional manager. We saw a referral had been made to the person's GP and to a dietician. However, an interim care plan was not written to ensure better support for nutritional needs being met. The senior carer on duty dealt with this straight away and we were given reassurance all people considered at risk

Is the service effective?

would be reviewed and care plans adjusted as required. We were also reassured although the plan was not written people were given additional supplementary food to support them.

We observed lunchtime during our visit. We noted people were given support and assistance as necessary to eat their food. All of the people we spoke with said that the food served in this home was good. We looked at the menus and found people were offered a variety of meals to choose from. One person old us they didn't like the choices for tea and said they would be given something entirely different.

They said, "I don't like curry or salad so I'll get something else. It's good like that. I enjoy most of my food. I don't go hungry." Meal times were unhurried and we observed drinks and snacks served at regular intervals.

We spoke with the cook and they confirmed they ordered fresh meat and vegetables and showed us the list of provisions ordered. Special diets were catered for such as diabetic and soft/pureed requirements. These foods were served as separate components on people's plates to allow people to experience different tastes. Cakes were homemade and staff had access to foods day and night for people needing or requesting snacks.

Is the service caring?

Our findings

The service had policies in place in relation to privacy and dignity. Staff induction covered principles of care such as privacy, dignity, independence, choice and rights. Two staff members were appointed their 'dignity in care' champions. Dignity meetings were held every three months. We looked at the results of a review of dignity, respect and privacy that had been conducted using a quality assurance monitoring exercise with people using the service. People were positive about their experience in this area and had added additional comments such as, 'The staff are great, always have been polite and gentle when they care for me.' And 'The staff are always polite and keep me clean and tidy.' 'Staff could not do better. I am happy with my care.'

People we spoke with said they were cared for very well. One person commented, "I have absolutely no complaints. I think the staff really do care. I like living here." People we spoke with also considered staff helped them maintain their dignity and were respectful to them. From our observations over the two days we were at the home, we found staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care. Calls for assistance were responded to promptly and staff communicated very well with people. Where people required one to one support such as with eating and personal care this was given in a dignified manner.

We spoke with two relatives visiting the home. They told us they were always kept informed about what was going on. One relative said, "I'm in every day so I know what is going on. I have to say I couldn't fault anything they do. The improvement in her general health is amazing. One thing I am impressed with is the way they treat me. I get to spend as much time with her as I want and I am invited to all the events that take place. She is always well dressed with attention to detail such as having her jewellery on. That tells me they have spent time with her and taken note of what she would have considered important to her. I'm really grateful for what they do." Relatives told us visiting arrangements were very good and they were made to feel welcome by all the staff.

We spoke to care staff on duty and discussed people's care needs and the support they provided. Staff gave a good account of and showed understanding of the varying needs of the different people we had discussed with them. Staff also knew what was important to people and what they should be mindful of when providing their care and support. Staff told us they enjoyed their work. One staff member said "I haven't worked here for very long. I'm really enjoying it. I think people are cared for very well."

We looked at three people's care plans and a selection of records relating to other people's care. We found they, or their relatives had been involved in on-going decisions about care and support and their preferred routines had been recorded. We noted people had not been asked about the preference for the gender of their carer and this could potentially compromise people's dignity as male and female carers were employed. This was dealt with during the visit by senior staff consulting people and or their family. We were assured this would be asked as routine when people were admitted to the home.

We observed some people spent time in the privacy of their bedrooms. Staff were seen to knock on their doors before entering. Doors were closed when personal care was being delivered. People had created a home from home environment in their room with personal effects such as family photographs, pictures and ornaments. Bedrooms had privacy locks and people were provided with a lockable drawer for personal use. People's comments included, "I like my room very much." "I like to watch my TV in my room. We are asked if we need anything." Comments from a quality monitoring exercise included, "I like the colour scheme in my room and my new wallpaper. I brought my own TV and all my things to make my room look nice." There were comfortable lounge areas and dining rooms with quiet seating areas. There was also a sensory room for people to relax in. Bathrooms and toilets had privacy locks and were suitably equipped for the people living in the home.

Is the service responsive?

Our findings

We looked at three completed pre admission assessments. These had been carried out by a suitably qualified member of staff. Information had been gathered from a variety of sources such as social workers, health professionals, and family and also from the individual. Information about the person's care and welfare needs and mental capacity was sufficient in detail to provide staff with some insight into their needs, expectations and life experience. People identified as having some difficulty making choices were supported during this process. We saw people who would act in their best interests were named, for example a relative. Emergency contact details for next of kin or another representative were recorded in care records as routine. Relatives told us they were always contacted if there were any significant changes to their relation's needs.

People were able to visit the home and meet with staff and other people who used the service before making any decision to move in. Short stays were offered allowing people to experience the service and make an informed choice about whether they wished to live in the home. One person told us, "I had been in another home for some rehabilitation following a stay in hospital. I knew I couldn't manage at home. As soon as I walked in the door it felt right. I came for a short stay but didn't want to move. I've been here for over two years now and I'm still happy."

The home had support systems in place to ensure they could respond to people's changing needs. For example staff told us there was a handover meeting at the start and end of each shift. Seniors attended this and told them how people were and if there any concerns they should know about. People were given additional support when they required this. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed. There was evidence of involvement with district nurses, dietician, community mental health team and other health and social care professionals involved in people's care. We spoke with two visiting health professionals. One health professional told us, "I visit a lot of homes and I can say I have no concerns here. Staff follow my instructions to the letter. They know the residents and give me a good report of people's symptoms when I come to see a new referral. They are all very good."

People we spoke with told us if they needed their doctor to visit this was arranged. Relatives we spoke with told us their family member received the right health care support to ensure their wellbeing. One relative told us, "They have been marvellous with her. If there are any problems they deal with it quickly. I have to say that since she came here there has been a marked improvement overall in her general well-being. She is more alert now and she seems to understand what they are saying. I'm really happy about this."

We found activities were being provided and were personalised. People had a personal journal to keep a record of what they had done every day. We spoke with the activity co-ordinator. She told us she tried to make sure interest's people had were maintained and the activities she organised catered for everyone. We observed people enjoying a board game, people spending time in the sensory room and a musical being watched in the lounge. Christmas trees were decorated with handmade decorations. People using the service told us activities were good. One person told us they would like to get out more. Plans were being made for the Christmas celebrations.

Visitors we spoke with told us they were invited to any social event planned for and if requested could have a meal when they visited. The hairdresser visited regularly and during our visit people had the opportunity to attend a church service in the home.

The service had a complaints procedure which was made available to people they supported and their family members. This was also displayed on the notice board. People we spoke with told us they knew how to make a complaint and felt confident any issue they raised would be dealt with promptly. We looked at the complaint record. One complaint was currently being dealt with. Complaints received at the service had been responded to by using the complaints procedure with details of the investigation carried out and conclusion recorded. The regional manager told us they welcomed any comment or complaint about the service as it helped improve customer service.

Is the service well-led?

Our findings

The manager at Hill View was registered with the Care Quality Commission (CQC). As registered manager they had the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was supported and monitored by the regional manager who visited the service on a monthly basis as part of quality monitoring and check the registered manager was meeting their obligations in meeting the required standards in the day to day running of the home. The registered manager kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area.

The provider had systems and procedures in place to monitor and assess the quality of their service delivery. These included for example, seeking the views of people they supported through satisfaction surveys some of which had a specific topic discussed such as people's experience of the food served and dignity issues. Results from a recent survey on dignity showed people placed their experience as being very good.

During the inspection we found the service was meeting the required legal obligations and conditions of registrations. The regional manager was able to describe the key challenges in the future. They had notified the commission of any notifiable incidents in the home in line with the current regulations.

We found there were processes in place to support the registered manager to account for actions, behaviours and the performance of staff. Contractual arrangements with staff outlined policies and procedures in place that, if required, staff who were subject to disciplinary procedures for gross misconduct and found to be no longer fit to work in health or social care, would be referred to the appropriate bodies. Contractual arrangements also precluded staff from gaining financially from people they cared for. Accountability for staff performance was evident with check lists completed for daily tasks and personal care provided.

Meetings were being held for staff, management and people using the service. Staff confirmed they had meetings, had supervision and also had appraisals and were supported by the registered manager. One staff member told us, "The manager and the senior staff are approachable. We can have our say at meetings. Since last year things have improved and I feel there is more structure to our work. I think we have more of a team spirit." Another staff member told us, "If I wasn't happy about anything I would say so. I'm confident they would deal with any issue relating to residents care and welfare immediately."

We found quality assurance was carried out regularly with regard to the operation of the home. This covered the environment, care and welfare of people, and staffing issues. Guidance was followed such as health and safety in the work place, infection control, and fire regulations. We saw well maintained and organised records of regular audits in key areas of care delivery carried out such as medication, health and safety, staff training records, care plans, the environment and catering requirements. Quality of life audits also included complaints, safeguarding, accidents and incidents, and infection control. Records showed where any shortfall had been identified this had been addressed by an action plan and further monitoring. There was evidence that learning from incidents, investigations took place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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