The Regard Partnership Limited

Hill View

Inspection report

Hill View
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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?	Requires Improvement

Summary of findings

Overall summary

Hill View provides accommodation in a purpose built building for up to six adults with physical and learning disabilities. There is a second home on the same site and both are run by the Regard Partnership Limited, which is a national provider of care. There were six people living at Hill View at the time of our inspection. People's needs were varied and included requiring support associated with cerebral palsy and epilepsy. People had complex communication needs and required staff who knew them well to meet their needs.

There was a registered manager in post. 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.

This comprehensive unannounced inspection took place on 20 and 23 June 2017.

At the last inspection we found some areas of practice that required improvement. For example, we observed some practices were not always caring. At this inspection observed a caring approach. Staff talked and communicated with people in a way they could understand. They had a very good rapport with them and people responded very warmly to staff.

At the last inspection we found improvements were needed in relation to some documentation for example in relation to satisfaction surveys and in relation to people's records. At this inspection we found significant progress had been made in relation to record keeping. However, there were some areas where further development was needed and we made a recommendation about monitoring documentation.

Staff had a very good understanding of people as individuals, their needs and interests. Some people attended day centres and people were also supported with daily activities both within and outside of the home. Staff supported people in a way that suited them. Staff were kind and caring in their approach and spoke with people in a way people could understand. People were supported to take an annual holiday.

The registered manager and staff had a good understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS are regulations that have to be followed to ensure people who cannot make decisions for themselves are protected. They also ensured people were not having their freedom restricted or deprived unnecessarily.

There were enough staff who had been appropriately recruited, to meet people's needs. Staff had a good understanding of the risks associated with supporting people. They knew what actions to take to mitigate these risks and provide a safe environment for people to live. Staff understood what they needed to do to protect people from the risk of abuse.

Staff attended regular supervision meetings and told us they were very well supported by the management

of the home. Staff meetings were used to ensure staff were kept up to date on the running of the home and to hear their views on day to day issues. Staff attended regular training to ensure they could meet people's needs. There was a thorough induction to the service and staff felt confident to meet people's needs before they worked independently.

People were supported to have healthy and nutritious diets that were varied and met their individual choices. They were also supported to attend healthcare appointments in line with their individual needs.

The provider had good systems to monitor the management and quality of the home and through regular internal monitoring the registered manager ensured a range of audits were carried out to monitor the care and support provided. Where shortfalls had been identified they were addressed in a timely manner.

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's medicines were stored, administered and disposed of safely.

Staff had a good understanding of the risks associated with the people they supported.

Recruitment procedures ensured only suitable people worked at the home. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff sought people's consent before providing all aspects of care and support. Staff received specialist training to support people effectively.

People were supported to access a range of health care professionals to help ensure their general health was maintained. Support was provided in the way people wanted to receive it.

The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were treated with warmth, kindness and respect.

Staff knew people well and displayed kindness and compassion when supporting people. People's dignity and privacy was promoted.

Staff adapted their approach to meet people's individual needs and to ensure care was provided in a way that met their particular needs and wishes.

Is the service responsive?

Good

The service was responsive.

People received support that was responsive to their needs because staff knew them well and support plans also contained guidance to ensure staff knew how to support people.

People were supported to take part in activities of their choice.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Record keeping did not always state people's changed needs and how they should be met.

A wide range of audits were carried out to monitor the running of the home and to ensure it was well run.

There was a positive and open culture at the home. Staff told us the registered manager was supportive and approachable. They were readily available and responded to what staff told them.

Hill View

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 comprehensive inspection took place on 20 and 23 June 2017 and was unannounced. When planning the inspection we took account of the size of the service and that some people at the home could find visitors unsettling. As a result, this inspection was carried out by one 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 reviewed other information we held about the home. This included notifications of events that had affected the service such as any safeguarding investigations. We received feedback from a visiting health professional.

Most people were unable to tell us about their experience of life at Hill View so we spent time observing the care they experienced. We were able to see the interaction between people and staff and watched how people were being cared for by staff. We met one person, two care staff, the registered manager and the locality manager.

We reviewed two people's care plans and risk assessments, recruitment records for two members of staff, quality monitoring audits and other records relating to the management of the home.

Good

Is the service safe?

Our findings

Although most people could not tell us if they felt safe, those who could communicate verbally said they did and we observed people were content in their surroundings. We saw if a person was anxious, staff were immediately on hand to provide reassurance and to address what was bothering them.

All staff had received fire safety training. There were regular fire safety checks. A fire risk assessment had been carried out in February 2015 and the emergency evacuation procedure was reviewed in August 2016. Regular fire drills were carried out and records demonstrated staff responded appropriately when the alarms sounded. There was an up to date personal emergency evacuation plan (PEEP) for each person that described the support they required in the event of a fire or emergency. In respect of three people there was a stay put policy in the event of a fire at night. We discussed this policy with the locality manager. By the second day of our inspection the registered manager advised the policy had been changed to ensure staff evacuated people in the event of a fire at night. All staff had been notified of the change in procedure. In addition, the service was taking further advice from the fire brigade to ensure their procedures were safe.

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults.

There were good systems to ensure equipment was serviced, checked and maintained. This included regular checks on equipment, weighing scales, hoists and wheelchairs. Water temperatures had been tested weekly and portable appliances annually. There was a pictorial health and safety checklist so people could be involved in the process. Where they had taken part in the process this was recorded.

Staff told us there were enough staff to meet people's individual needs. There were clear on call arrangements for evening and weekends and staff knew who to call in an emergency. There were three staff on duty throughout the day and a waking night staff member. In addition, at night there was a sleep-in staff member who was shared across both homes on the same site. This person assisted where needed for a set number of hours and was then called on, only if necessary, during the night hours. We were told that alongside the normal staff arrangements, the rotas also included set hours that most people were funded to receive for one to one support with activities throughout the day. Details of the staff support provided were recorded in a personal daily outcome folder for each person.

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in locked cupboards in their bedrooms. Support plans included detailed advice about how people chose to take their medicines. Where people were prescribed skin creams, body charts were used to highlight the specific areas to be treated and advice was given about how much cream to apply. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain or were agitated. Before giving PRN medicines, staff would discuss the need with the registered manager or most senior person on duty to ensure this was the most

appropriate treatment for the person at the time. Not everybody who experienced pain was able to express this verbally, and there was information in people's care plans about how they may express they were in pain. If people declined medicines this was recorded and advice sought from the person's GP or on-call doctor. Staff had completed training on medicines and had been assessed as competent before being allowed to give medicines to ensure they followed correct procedures.

There were robust systems for the recording of accidents and incidents. There were detailed records with information about what had happened and the actions taken. Where appropriate, following accidents and incidents, advice was given to ensure risk assessments were reviewed and updated. Staff had an understanding of different types of abuse and told us what actions they would take if they believed people were at risk. All staff had received training in safeguarding and were able to tell us that if an incident occurred they reported it to the registered manager who was responsible for referring the matter to the local safeguarding authority. There was also a detailed safeguarding policy and procedure in the office which included contact numbers so that any staff member could make a referral if this was needed.

Good

Is the service effective?

Our findings

Staff knew people well; they had the knowledge and skills to look after them. Staff sought consent from people before providing them with any care or support. A visiting professional told us, "Staff are very welcoming and open to advice." Those who could tell us verbally said the food was good. Staff knew people's likes and dislikes and offered a choice of menu to meet individual tastes.

People were supported to have enough to eat and drink to maintain their health and well-being. Menus were varied, nutritious and well balanced. They were displayed in the dining room along with a picture of each meal. One person had a restricted diet. Staff were able to tell us how and why it was important to ensure the person received a restricted diet to meet their identified health needs. Records showed some people could choose what meals they wanted and some people used body language, for example pointing to a picture to make their choices known. Staff told us some people were not able to make meal choices, so choices were made for them based on their known preferences. Staff told us if a person did not want a particular meal when it was served, they would be able to tell staff they did not want it by pushing the plate away. When this happened they were given an appropriate alternative.

Records showed staff had completed training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff were able to describe MCA principles and some of the areas that may constitute a deprivation of liberty. 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. There was information within care plans about how each person communicated their needs and wishes and staff were able to describe how each person made their needs known. Staff knew that if people were unable to make complex decisions, for example about medical treatment, a relative or advocate would be asked to support them and a best interests decision reached to ensure all proposed treatments were in their best interest.

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 checked whether the service was working within the principles of the MCA, and whether conditions on authorisations to deprive a person of their liberty were being met and there was appropriate documentation. We were told a number of standard authorisations had been applied for. Where it had been assessed restrictions were needed, for example for the use of lap belts, a restrictive practice intervention form had been completed. These forms showed why it had been assessed as necessary, how this had been discussed or attempted to be discussed with the person and who had been involved in reaching the decision.

People received effective care from trained and knowledgeable staff. A record was kept of staff's individual training needs and the registered manager ensured that when updates were needed staff were given timescales for completion. Staff received training in looking after people, for example in safeguarding, food

hygiene, fire evacuation, moving and handling, health and safety and infection control. One of the staff team had a train the trainer qualification in moving and handling and they ensured all staff were up to date with this training. Staff showed they understood how to assist people through the use of good moving and handling techniques when they supported people to move about the home.

Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were competent to work unsupervised. They also received additional training specific to peoples' needs, for example, the management of behaviours that challenged, equality and diversity and training on cerebral palsy. Staff were able to give example so how they respected people' uniqueness, treated them as individuals and respected their differences. Examples given included, respecting the need for one person's specialist diet and respecting one person did not like staff to be too close and another did not want to join people at the table for meals. They said whilst it was important to offer choice it was also important to hear and respect the choices made especially when people could not always express themselves verbally. There were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care at a level appropriate to them. The registered manager was studying for a level 5 qualification.

There were appropriate systems that ensured staff received ongoing support. Records confirmed staff attended supervision meetings every other month. A staff member told us, "We don't need to wait, we can have one earlier if we want. A staff member told us the registered manager was, "Very supportive and helpful." Another told us, "I'm 100% supported."

People were supported to maintain good health and received on-going healthcare support. Everybody had a health action plan that identified the health professionals involved in their care for example, the GP, optician and dentist. They contained important information about the person's health needs. Where a professional had written guidelines or recommended particular exercises to be carried out with people, these were included in care plans and followed. People also had care passports that would be used if they needed to go into hospital. Care passports were used to describe information that might be needed if the person were to go into hospital. This included, "Things you must know about me," "Things that are important to me" and "My likes and dislikes."

Good

Is the service caring?

Our findings

At the last inspection we found areas of practice that did not demonstrate staff were always caring in their approach. At this inspection we found actions had been taken to make improvements. Staff knew people well and knew their likes and dislikes. We observed staff talking and communicating with people in a way they could understand. They had a very good rapport with people and people responded very warmly to staff. A visiting professional told us "I have always found it to be a very homely home."

One person liked to see that everyone was treated equally. A staff member offered us a cup of tea. When this was made the person said to another staff member, "Where's yours," meaning the staff member had not made them a cup. This was duly offered and made and the person said, "That's that done." There was a look of contentment on the person's face.

Staff respected the choices people made. One person liked to have their meals in an unconventional way, close to but not with others. Staff continued to offer the person the opportunity to join their peers but their decision to eat meals in the way they did was respected.

Bedrooms had been personalised to reflect the people's individual tastes and interests. One person had recently bought new furniture and was very keen to show us. Their room had been decorated in a way that meant they had easy access to items of importance to them. They were very proud of their room and thoroughly enjoyed showing us their photograph albums of their various holidays.

Staff knocked on people's doors before they entered the room. They said they maintained people's dignity by ensuring people's doors and curtains were always kept closed whilst they attended to their personal needs. They also said they ensured people were kept covered as much as possible when providing personal care. One person was unable to use the call bell system so staff fitted a 'bell pull' system which the person could use more easily.

Staff were observant and attentive to people's needs. The SOFI and general observations showed interactions between staff and people were caring and professional. When staff approached people they did so respectfully and people knew staff were addressing them. People's individual needs were accommodated and their dignity and independence was maintained. All support was provided discretely. At mealtimes staff sat with people and supported those who needed assistance. They interacted well with people to ensure mealtimes were a pleasurable experience.

Staff told us some people were able to make definite choices about what they wanted to do and with others there was a process of elimination until they found an activity that suited them. Records showed one person had been offered a sensory food activity. The person had shown they did not want to participate by dropping items on the floor. Staff recognised the person did not want to do this and instead they were offered time in their bedroom with their sensory lights and listening to music. The records showed this had been an enjoyable activity.

Good

Is the service responsive?

Our findings

People received support that met their needs and was personalised to their individual choices and preferences. They made use of local facilities and amenities and were supported to receive an annual holiday.

There was a range of documentation held for each person related to their care needs. This included information about their medical needs, support needs and ability to give consent. The records contained detailed information and guidance about people's routines, and the support they required to meet their individual needs. One person's mobility needs had changed significantly in the previous months. Professional support had been sought. A new bed was bought and a hand rail fitted on their wall. Another person had an overhead tracking hoists in their bedroom and some people had wheelchairs. Where people needed support to move around the home, professional guidance had been sought and there were guidelines to ensure this was done in a way that suited them. Care plans were detailed and gave a very clear picture of people's personality, likes and dislikes. For example, one person liked to stay up late and to wake up early. One person sometimes displayed behaviours that had the potential to cause them harm. Staff were able to tell us the techniques they used to distract the person from these behaviours and to help them to settle.

We observed staff supporting people and their knowledge of them as individuals helped them to communicate effectively with people. There was a complaints policy and an easy read version was also on display. A speaking out form was available to record any concerns people might raise. People were regularly asked if they were happy or if there was anything they would like to do differently. For example, at residents' meetings people had opportunities to say if they were unhappy. The last complaint recorded was in 2014. Staff were able to tell us some of the signs people who could not communicate verbally would use to indicate they were unhappy and we saw staff responded to people when they indicated signs of unhappiness. A visiting professional told us they had provided, "Support and advice to assist with developing an inclusive communication environment." The registered manager told us that as part of this a staff member had recently been allocated the role of communication champion. They and the registered manager had recently signed up a course that would help them to develop the role further.

Resident's meetings were held regularly. These were recorded in an easy read format which used pictures to enhance understanding. There were several set topics that were discussed at each meeting along with seasonal and ad hoc matters that arose. The registered manager told us whilst they were happy with the recording generally, they wanted to develop this area further. They were hoping to buy and use an electronic tablet to demonstrate more clearly the choices presented to people and their responses.

One person attended a day centre three days a week. Others went to a monthly disco and attended a regular club. One person was supported to visit their relative every other week. Those who chose to, received regular aromatherapy. An activities board was displayed in the entrance hall. Each person was supported to use local amenities on an almost daily basis. Activities based in the home included arts and crafts and baking. Some people enjoyed sensory activities and others enjoyed music sessions.

People enjoyed an annual holiday and if able were supported to choose their destinations. At the time of inspection two people were away on their annual holiday. Another two had already been on holiday and there were plans for the remaining two people to go on holiday. People were supported to create photo albums of their holidays which meant staff and family members were able to speak with people about where they had been and what they had done.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found areas of practice that did not demonstrate that the service was always well-led. At this inspection we found significant progress had been made, but there were still a couple of areas in relation to record keeping that required improvement. There was a positive and open culture at the home. A staff member told us the registered manager was, "A really good manager. She is approachable. If you tell her something has gone wrong she will help you to deal with it." There was a new manager who had recently been registered with the Commission. The registered manager told us when they had started working in the home they had received a very good induction and the locality manager had been, "very supportive." They said there was a good support network between the managers locally which meant between them there was always someone available to call on if they needed support.

Despite the positive comments we found some minor shortfalls in record keeping. Staff told us one person regularly refused an aspect of personal care. It was evident the home had sought professional advice on this matter and a visiting professional offered treatment every six weeks. However, staff were not able to tell us when treatment had last been provided. There was no care plan or risk assessment in relation to this and whilst staff told us they regularly tried to provide this care, this had not been documented. Whilst the person had the right to refuse this care, the impact of not receiving this care had not been assessed both in relation to the impact on them and on staff. By the second day of our inspection staff had created a new care plan and risk assessment.

We found one example where the registered manager had not ensured that a best interests decision had been made in relation to a health procedure for one person but this had been resolved by the end of our inspection.

We recommend the registered provider continues to monitor that care plan documentation reflects people's specific needs as they change and how they should be met.

The registered manager had a system of carrying out observations of staff to ensure they were providing safe and appropriate care to people. Where shortfalls were found the registered manager arranged a time to discuss the shortfalls and to discuss different approaches that could be used.

The organisation continued to have good quality monitoring systems which included quarterly internal audits. Where shortfalls had been identified for example, it was recommended more detailed record keeping was made in relation to people's meals, these had been addressed. There were systems to support staff in monitoring health and safety. There was also a pictorial first aid box checklist and this enabled people to be involved in assisting staff in making sure the contents were appropriate and in date. The registered manager carried out regular audits of the service for example in relation to medicines, care plans and cleanliness and a locality manager visited monthly to carry out a service review. Part of this process involved a check that any previous recommendations had been addressed. The home received an annual visit from their pharmacist who checks the procedures for the management of medicines. The last visit was in May 2017 and everything was found to be in order.

Minutes of staff meetings were detailed and showed staff were encouraged to have a say on the running of the home. All discussions were documented, along with the actions reached, so that if a staff member had not been at the meeting they would understand the agreed actions and outcomes. The manager had introduced a system whereby a policy was discussed at each meeting. In May staff had discussed the organisations' policy on dignity and respect.

Records of all accidents and incidents were reported to the organisation and were not closed until they had been reviewed by locality manager. Records showed following one incident a person had received medical support and had been diagnosed with a particular condition. The person's care plan had been updated to include information about the condition so staff would know how to deal with this should a similar incident occur. The registered manager sent notifications to CQC when appropriate. A notification is information about important events which the provider is required to tell us about.

On the first day of our inspection the registered manager had been on a course, 'Getting the best out of your team.' They told us the course had been very positive. They had examined different styles of leadership and approaches to managing different situations. They said they had lots of ideas for team building. Although they already felt the staff team worked well together they were looking forward to building and even stronger and more cohesive team.

Staff meetings were held monthly and staff said they were updated about new ideas and changes that took place. Detailed minutes were kept of the outcome and demonstrated a range of matters had been discussed and action plans had been agreed. At the last staff meeting they had discussed the home's equality and diversity policy. The registered manager told us they chose a different policy to discuss at each meeting and this ensured staff were kept up to date with the home's policies and procedures. All staff had to sign they had read the minutes and the policy discussed so this ensured staff that had not attended the meeting were also kept up to date.

Staff surveys had only recently been sent for completion so the outcome was not known at the time of inspection. The organisation had awarded the home a 'living our values' award for a period of time when they had been without a registered manager. There had been a two month gap between the previous manager transferring to another service and the new manager starting in post. Temporary management arrangements had been put in place and the staff team had shared a number of responsibilities to ensure the smooth running of the service. A staff member told us this period had given them a greater insight into the role of a manager. They said the new manager had enabled staff to retain responsibility for certain areas to enable them to develop their skills further and they welcomed this.