Harbour Healthcare Ltd

Hilltop Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Hilltop Court Nursing Home on 8 and 9 May 2018. The inspection was prompted in part by a Regulation 28 Report we had received from the Coroner relating to evidence given at a recent Inquest. The information shared with Care Quality Commission about evidence given that raised concerns about the arrangements, supervision and management of risk of potential choking involving people who used the service. This inspection examined those risks and looked at what reasonable and practicable action had been taken by the registered provider to help reduce any future risks. We were not aware and were informed by the registered manager that no-one had died from choking at the home.

We also checked that improvements to meet legal requirements planned by the provider after our comprehensive inspection which was undertaken on 27 and 28 November 2017 had been carried out. These related to breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulation Activities) Safe Care and Treatment and Regulation 17 of the Health and Social Care Act 2008 (Regulation Activities) Good Governance. The home was rated requires improvement in safe and well led with an overall rating of requires improvement. At this inspection although improvements had been made to the shortfalls we found at the last inspection, further shortfalls were found.

The registered provider sent us an action plan. This action plan was not yet out of the set timescale given by the registered provider. However, contact was made with the registered provider who agreed that we could check what improvements had been made since our last inspection. We also looked at additional continuous improvements made by the registered manager since our last inspection.

Because of the concerns we had received an adult social care services inspector and a specialist professional advisor (SPA) who was a qualified Speech and Language Therapist (SALT) undertook this inspection. A SALT is a qualified healthcare professional who provides treatment, advice, support and care for people who have difficulties with communication and/or eating, drinking and swallowing. At this inspection we only focussed on the safe and well led sections of the report. The last comprehensive inspection can be found on our website www.cqc.org.uk/sites/default/files/new_reports/INS2-3069399060.pdf.

Hilltop Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hilltop Court Nursing Home accommodates up to 50 people on two floors in single sex units. The home provides care to people living with advanced dementia. A person who is living with the later stages of dementia is likely to experience severe memory loss, have problems communicating with others and need additional support with daily activities, including eating and drinking.

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. There was a registered manager in place at the time of our inspection.

We found that the health and safety shortfalls we found at the last inspection had been satisfactorily addressed. Stairwells were kept free from electrical items, and the outstanding item on the homes fire risk assessment had been completed and signed off. A risk assessment had been carried out for mouse bait visible in the dining area and maintenance books had been to be signed off by a senior person.

We looked at the arrangements for monitoring nutrition and hydration for people including the risk of choking. We were told that when the home made a referral to the speech and language team there could be a delay of up to four weeks before the person had a speech and language therapist (SALT) assessment undertaken, which meant the home was reliant on developing their own risk assessments. However, there was no clear evidence on the service's records to indicate there could be a delay of up to four weeks before an assessment could take place.

Risk assessments used to determine people's level of choking risk were not always effective in capturing all the potential signs of aspiration and/or choking. One record we saw showed that it had not been kept under regular review.

We found discrepancies in the records we saw between a care plan, daily recording and handover sheet in terms of texture of food requirements. The handover sheet used between different teams of staff identified those people at high risk of choking and we found this was out of date and contained the names of several deceased people.

We found evidence of a 'near miss' which had occurred that had not been formally reported. The lack of reporting was a missed the opportunity to report to senior management an incident that may indicate the need for higher levels of supervision in order to minimise risk to that individual.

The registered manager demonstrated a good understanding of some of the signs of aspiration and potential choking and expressed confidence in her staffs' knowledge and responsiveness to such signs. However, staff training records did not indicate that staff had received the training they needed to increase their awareness of the risk of choking and to help prevent it from happening. The registered provider took immediate action to ensure that this training would be undertaken by all staff and completed by 30 June 2018.

You can see what action we told the provider to take at the back of the full version of the report.

The registered provider had started to take action to help reduce the risks identified by the Coroner. This included introducing two sittings for meals. One for those people who eat in the dining room and a second sitting to enable staff to support people who eat in their rooms and for those people who choose to walk and eat to ensure any discarded food is disposed of safely. The registered manager and care quality lead informed us that since the incident there had been and increase in staffing levels to support people safely and effectively.

We observed a pleasant and positive mealtime experience for those people using the service. There was a good balance between supporting people and encouraging them to be as independent as possible. Appropriate texture of food and drink was provided at lunch.

Basic information on diet modifications for each person was kept on a laminated sheet in the dining room. Daily recording on an online system contained regular references to food and fluid intake people had taken and written records were also appropriately maintained.

Staff members in the dining room were responsive to individual people's needs and personalities and were quick to pick up if someone needed help. They worked well as a team to achieve this.

A new "patient passport" document was in the process of being implemented and eleven had been completed by the end of the inspection. These patient passports will include more detailed information on patients' eating and drinking needs, as well as communication needs and other health support requirements.

We were informed that a SALT student placement programme was due to start at the home in the near future. If supported correctly this may help to increase awareness of the eating, drinking and communication needs of people within the service.

We saw that the registered manager had been proactive in looking at ways to improve the service. The Stockport Red Bag Pathway is an initiative to improve communication between the hospital and the home. The registered manager was in the process of arranging to take student nurses for practice placements and arranged training sessions with a local healthcare provider about catheterisation and blood taking in exchange for the staff from the local healthcare provider to attend dementia, mental capacity act and deprivation of liberty safeguards (DoLS) training. During the forthcoming dementia week the registered manager of the home had made arrangements to provide dementia awareness sessions at two high schools in the local area.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found shortfalls relating to people's care records and risk assessments in relation to eating and drinking.

Evidence could not be found to support that staff had received the training they needed to support people who had difficulties eating and drinking safely. This training is necessary to help prevent the risk of people choking.

We found that satisfactory improvements had been made in relation to health and safety of the premises.

Is the service well-led?

Requires Improvement

This service was not always well led.

We found improvements had been made in relation to health and safety monitoring of the home. However, the registered provider's quality monitoring systems continued not to identify the shortfalls we found.

The registered provider took immediate action to address these shortfalls and those of the Coroner.

Hilltop Court Nursing 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.

The inspection was prompted because we had received information of concern from the Coroner in the form of a Regulation 28 Report. A Regulation 28 Report (Prevention of Future Death Report – PFD) is issued by the Coroner if during the course of an Inquest concerns are raised which identified if appropriate action is not taken a risk of deaths will continue to exist in the future. The Coroner has a duty to issue a report to a person, organisation, local authority or government department or agency. In this case, both the service and the Care Quality Commission (CQC) had to respond. The death related to natural causes.

Information shared with the CQC about preventable future deaths related to arrangements, supervision and management of choking risk to people using the service. This inspection examined those risks and looked at what action had been taken to reduce any further risks.

Before our inspection we carried out a Coroners and notifications qualitative risk report. This highlighted three other deaths where people had been on modified diets. We checked with the Coroner's Office and were informed that no post-mortem's had been carried out on all three deaths and were recorded as death by natural causes.

This inspection took place on 8 and 9 May 2018 and was unannounced. An adult social care inspector and a Speech and Language Therapist (SALT) carried out the inspection. A SALT is a qualified healthcare professional who provides treatment, support and care for people who have difficulties with communication and/or eating, drinking and swallowing.

We spoke with the registered manager, the regional manager, the operations director, the quality care lead , the assistant manager, a registered nurse, two support workers and two maintenance workers. We case tracked the records of three people who were at risk of choking and briefly at a fourth person's records and held discussions with staff following the lunchtime observation on the female unit. We also carried out an

observation of lunchtime on the male unit.

We looked around parts of the home and at records relating to the management oversight of the service. Following the inspection we had a telephone conversation with the managing director for the organisation who confirmed what immediate action the registered provider was going to take to make improvements in those areas identified from the inspection.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that the service was not always safe. At this inspection although improvements had been made in relation to the shortfalls we found at our last inspection, further concerns were found. This domain therefore remains requires improvement.

At our last inspection the home was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found a number of shortfalls relating to health and safety around the home.

The shortfalls included that stairwells should be kept free from the storage of electrical items, that the outstanding item on the homes fire risk assessment was completed and signed off, that a risk assessment was carried out for mouse bait visible in the dining area and maintenance books needed to be signed off by a senior person. We found these shortfalls had been satisfactorily addressed.

We were informed that since our last inspection the registered manager, regional manager and the maintenance team had completed an Institution of Occupational Safety and Health (IOSH) training course. Regular meetings were now taking place so that maintenance personal could raise any concerns they had and share ideas. The maintenance people we spoke to confirmed this. The home had also sought the advice of a health and safety consultant. This action should help to improve health and safety at the home.

When we arrived at the home staff were in the process of setting up for a party to enable people to celebrate VE day. This included putting bunting up round the home and staff dressing up with entertainment provided by singers, followed by a buffet.

Most of the people living at the home lived with advanced dementia. At the time of our inspection, 70% of the people who lived at the home were receiving a modified diet and therefore could be at risk of choking.

Discussions with the registered manager and quality care lead told us that there was the potential that everyone who lived at the home could be on a modified diet.

A good rapport between staff and people who use the service was observed throughout the day. The atmosphere in the dining room during lunchtime was pleasant, relaxed and jovial. Although staff present in the dining room were extremely busy given the needs of the people, there was at no point a sense of stress or of any element of care being rushed.

Observation at lunchtime provided good evidence that the staff present that day were skilled in terms of their approach to supporting the needs of this group of people. Appropriately modified textures were provided for each person. Clear and sensitive communication was observed both in terms of establishing good rapport with people to maintain the maximum level of awareness with people who needed full support with eating, for example, explaining when another spoonful was being offered and reminding people to chew or swallow. Staff were aware of the need to wait for a person to swallow and clear their

mouth before more food was given.

For people who struggled to maintain their attention during the meal this was handled sensitively and effectively, for example, gently encouraging a person whilst also minimising conversation that might divert them from eating safely. There was a good approach to optimising independence. We saw the same person was supported to move from being fully supported towards eating more independently as their level of engagement and awareness increased during the meal.

Everyone was to have a 'Patient Passport' which included a section 'My Eating and Drinking' which included the type of diet, fluids, assistance and in my best interests, encourage me to choose a healthy option, have a smaller portion, eat calorie rich fortified foods and have a larger portion. The registered manager told us that eleven had been completed at the time of the inspection.

We were informed that a SALT student placement programme was planned and due to start in the near future. If supported correctly this may help to increase awareness of the eating, drinking and communication needs of people within the service. We also saw that the service was involved in oral health care. A session about mouth care matters being held at a local hospital was to be attended by the registered manager, assistant manager and two senior carers. Good oral health care can help people to eat better. We will review this at our last inspection.

We were told by the registered manager that there could be up to four weeks wait before an assessment was undertaken by a SALT. In the interim period they were reliant on their own assessments. There was no evidence to support when a request for an assessment by a SALT was made because a fax system was used.

Information provided following assessment by a SALT was recorded in the daily record by a member of staff on duty at the time of assessment and a photocopied leaflet about signs of choking was in the file with appropriate texture descriptors for this patient hand-ticked by the SALT. No written report or advice from the SALT was found. This was not supportive of the sharing of accurate information following a SALT assessment, and this could potentially compromise people's safety.

During this inspection we checked the care records of three people selected at random and briefly a fourth person's records and held discussions with staff following the lunchtime observation on the female unit.

We looked at the risk management plans that were in place to guide staff on the action to take to reduce the identified risks. We found that each person whose records we reviewed had a choking risk assessment and a dietary needs care plan in place and had some reference to a SALT assessment in their records.

We saw there was basic written information about food and drink texture adaptations for each person which was available in the female dining room.

During the lunchtime observation, we observed a brief choking incident followed by the person vomiting. The staff in the dining room were very responsive and were seen to work well together in terms of calling to each other about the patient's colour, i.e. whether the person showed signs of lack of oxygen, and organising who would leave the dining room to alert the nurse on duty. A nurse arrived swiftly and checked the person and also returned approximately ten minutes later to check again on the person's recovery.

We briefly reviewed the care record for this person following the incident. This person was recorded as being at low risk of choking. The risk assessment form for choking had been reviewed and it contained no option for including if the person was vomiting following eating in order to calculate overall risk. We were not

confident that the questions asked on the assessment would capture all possible signs and symptoms that would indicate an increased risk of choking or aspiration. A staff member also commented that the person vomited after or during meals due to "trapped wind". This raised concerns about the level of knowledge and awareness about signs of choking and aspiration for some staff, as vomiting after or during meals is one of the signs of dysphasia. This issue was discussed with the registered manager who told us they would review the person's risk assessment.

Information about specific food texture requirements for one person we reviewed was not consistent between SALT advice, care plan and carers handover sheet. This person had been recommended a fork mashable diet by the SALT, and was observed being given this texture during lunchtime and the correct information was included in the carer handover sheet. However, in the care plan it was recorded the person required a pureed diet. When this was pointed out to the registered manager she changed the information on the care plan but did not indicate how this alteration would be communicated to the staff team.

One person's care plan had only five reviews recorded between October 2016 and the end of March 2018. One of which in March 2017 was signed by an agency nurse, even though the previous review by a regular member of staff had been carried out five months previously and the next review by a regular member of staff was three months afterwards. This left a gap of eight months between reviews by a regular member of staff.

Discussion with the registered manager indicated that the care plans for dietary needs were reviewed monthly as a minimum standard, or sooner if any concerns or changes to a patient's presentation were noted. This was not represented in the care records for the person reviewed. We were told that this may have happened because there was a problem with the computerised care planning system and if not used correctly by agency staff could be accidently delete reviews undertaken. We were informed by the maintenance director that plans were in place to replace the current computerised system with an internet system that would prevent this from happening again.

During the review of another person's care notes we found an entry in April 2018 detailing an incident in which a member of staff reported finding half a biscuit on person's blanket while they were in bed, and they appeared to have something in their mouth. The person had been checked to ensure there were no signs of choking. This person was on a pureed diet due to high risk of choking. Although this was recorded in the notes as an incident, there was no evidence that further action had been taken in terms of discovering how this had occurred and no evidence that steps had been taken to ensure that the risk of this happening again was minimised. When raised with the registered manager they had not been made aware of this particular incident.

Discussion with the registered manager confirmed that they thought that all staff were trained and aware of the signs and symptoms of choking and aspiration. Training records we saw showed that not all staff had received the training they needed to understand dysphasia and the risk of choking. The registered provider took immediate action to address this issue.

The shortfalls we saw are a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found that the service was not always well-led. At this inspection although improvements had been in relation to the shortfalls we found at our last inspection, further concerns were found. This domain therefore remains requires improvement.

At our last inspection we found the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. This was because we found shortfalls in health and safety around the home. The services quality assurance systems had identified work that needed to be carried out to make improvements at the home but this had not been carried out in a timely manner.

Following the last inspection the registered provider sent us a plan that informed us of what action they intended to take to ensure that the service reached a rating of 'good' in well led.

At this inspection we found that action had been taken to address the shortfalls found in health and safety at the home. We saw that there was now only one service improvement plan in place at the home instead of two, which helped to reduce any confusion about what work needed to be undertaken. The regional manager told us that plans were in place to make improvements to the conservatory area which was also the entrance of the home and problems with a small number of radiators during Summer 2018.

We saw that the registered provider had started to put an action in place to address the concerns raised by the Coroner in the Regulation 28 Report. This included introducing two sittings for meals. One for those people who eat in the dining room and a second sitting to enable staff to support people who eat in their rooms and for those people who choose to walk and eat to ensure any discarded food is disposed of safely. Patient passports were being put in place and the handover sheet had been updated to include dietary needs. Following our visit all staff were to complete online training in Hydration and Nutrition which included special diets and dysphasia awareness. Practical sessions were also being organised in dysphasia training to be undertaken by all staff by 30 June 2018. We will review this at our next inspection.

At this inspection we found shortfalls in people's records, which was due in part to the present computerised system. We were told that the registered provider was in the early stages of upgrading the computerised care planning system across all homes nationally. The managing director told us consideration would be given to the home being involved in the early rollout of the new system.

We also had concerns about terms of reporting and responding to near misses and discrepancies in recording. There was no evidence to show appropriate action had been taken to address issues with delays of getting an assessment from the local SALT team or with more senior management within Harbour Healthcare.

These shortfalls meant that there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

We saw that the registered manager was proactive in looking for opportunities for making continuous improvements at the home, which included working in partnership with other organisations.

Recent improvements included the introduction of patient passports, supporting a SALT student programme, an oral health programme, mouth care matters with a local hospital, the Stockport Red Bag Pathway an initiative to improve communication between the hospital and the home. The red bag would contain copies of the person's Do Not Attempt Resuscitation (DNAR), Medicines Administration Records (MAR), the patient passport and personal belongings such as dentures, glasses, hearing aid and other essential personal items that were important to them.

The registered manager was in the process of arranging to take student nurses for practice placements and arranged some training with a local healthcare provider in catheterisation and blood taking in exchange for providing dementia, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training for the staff of the healthcare provider. During the forthcoming dementia week the registered manager had made arrangements to provide dementia awareness sessions at two high schools in the local area.

At our last inspection in November 2017 we commented that supervision records and the references available for a member of staff were insufficient. We checked these records and found improvements had been made in both.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People who use services and others were not protected against the risks associated with unsafe or unsuitable arrangements for eating and drinking. Regulation 12 (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People's records were not always accurate and complete. 'Near miss' incidents had not always been reported to the registered provider and registered manager. Regulation 17 (2) (1) (c)