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 effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on 27 and 28 November 2017.

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. The Care Quality Commission (CQC) regulates both the premises, the care provided, and both were looked at during this inspection.

Hilltop Court Nursing Home is situated close to Stockport town centre. The home provides nursing and personal care for up to 50 people. At the time of our inspection, 46 people were living at the home. People who used the service lived with advanced dementia. The home was on three floors named Coronation Avenue, Emmerdale Close and Wembley House.

We last carried out a comprehensive inspection on 31 August and 1 September 2016. At this inspection, we found the service was in breach of the regulations relating to the management of medicines and people's care and treatment records in relation to people's religious, cultural and end of life wishes and the availability of these records to all staff. The overall rating for the service was requires improvement.

We returned to the service to carry out a focussed follow up inspection on 25 April and 3 May 2017. Although we saw improvements had been made in relation to people's care records, there were still shortfalls in the management of medicines. The service was rerated to good. It should be noted that changes in our methodology on 1st November 2017 a service can no longer be rated good if it is in breach of a regulation.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions is the service safe and well led to at least good. At this inspection, we found that improvements had been made in relation to medicines management. However, we found concerns around the health and safety of the premises in relation to window restrictors and fire safety.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present during most of this inspection.

We raised concerns about fire safety at the premises and requested a visit by the Greater Manchester Fire and Rescue Service. We also raised concerns about the lack of tamper proof window restrictors in parts of the home. Action was taken to address this matter during the inspection.

Although the registered provider's quality assurance systems were identifying health and safety concerns, timely action to resolve them was not always taken.

You can see what action we have asked the registered provider to take at the end of the main report.

We recommend that all recent recruitment files are reviewed to ensure that the service is meeting requirements to ensure references are taken up with previous adult and children services employers.
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Staffing levels were sufficient to meet the needs of people who lived at the home.

Staff had received training in safeguarding adults. They were able to tell us of the action they would take to protect people who used the service from the risk of abuse.

Improvements had been made in medicines management. Systems were in place to reduce the risk of cross infection in the service; this included the use of personal protective equipment (PPE) where necessary and regular checks regarding the cleanliness of the environment.

Risk assessments were in place on people's care records to minimise the potential risk of harm to people during the delivery of their care.
The registered manager understood the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant they were working within the law to support people who may lack capacity to make their own decisions.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Staff had access to the training they needed to help support people safely and effectively. The registered provider had improved facilities for staff training and the registered manager was involved in developing more practical based and interactive dementia training with the online training provider.

People had limited verbal communication due to living with dementia. We observed staff providing support to people in a kind and patient way. The atmosphere at the home was calm and relaxed.

Care records we saw showed they were kept under reviewed however; more evidence was needed to show the involvement of family and friends.

The home provided a wide range of activities for people to be involved in, which included short bursts interactions to keep people stimulated. The home was working on a project with the Alzheimer's Society to look at the best ways to engage with people who live with advanced dementia.

There was a complaints procedure, which was on display. A record of all complaints and the action taken to resolve them was maintained.

The registered manager was working towards strengthening the management team but needed to be sure potential new management staff had the right communication skills and personal qualities to work with people living with advanced dementia.

Care staff and relatives we spoke with gave positive responses about the care people received at Hilltop Court.

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 had concerns about some aspects of health and safety around the premises, which included fire safety.

Staff had overall been safely recruited and there were enough staff to meet people's needs.

Improvements had been made to help ensure the safe administration of medicines.

Staff had received training in safeguarding vulnerable adults. There were systems in place to help ensure staff were supported to report any abuse they witnessed or suspected.

Is the service effective?

Good

The service was effective.

Staff received the induction and ongoing training they needed to be able to provide safe and effective care.

The registered manager had taken appropriate action to apply for restrictions to be put in place, if in a person's best interests, to be legally authorised.

People were supported to maintain good physical and mental health through regular monitoring in the service and attendance at external appointments.

Is the service caring?

Good

The service was caring.

The atmosphere in the home was relaxed and calm.

We saw frequent and friendly interactions between people who use the service and the staff supporting them.

Is the service responsive?

Good

The service was responsive.

Care plans were in place, outlining people's support needs.

Activities were taking place. We saw that the service had for people who lived with dementia.

Systems were in place to enable people to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

Although the homes quality assurance systems were identifying concerns, timely action had not always been taken to resolve them.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection so the service did not know we were coming and was undertaken by two adult social care inspectors.

Prior to our inspection, we contacted the local authority and clinical commissioning group (CCG) safeguarding and commissioning teams. We received information back from the local authority safeguarding and quality assurance teams. This information helps us to get a balanced view of the service and informs our inspection.

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 used this information to inform our inspection. We also reviewed the information we held about the service including the last two inspection reports and notifications the provider had made to us.

During the inspection, we spoke with two people who used the service and four relatives. We also spoke with the registered manager, the regional manager, two carers on nights, one nurse on days, one senior carer, four care staff and the activities co-ordinator.

We looked around most parts of the home and spent time observing how people were cared for. We also looked at a range of records relating to how the service was managed; these included medication records, staff recruitment files, staff training records and health and safety audits.

During our inspection, we carried out observations in public areas of the home and undertook a Short Observational Framework for Inspection (SOFI). A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Since our last inspection, the service had been subject of a Regulation 28 Report following an inquest. The coroner requested action be taken by the registered provider to help prevent any future deaths at Hilltop Court and other premises owned by the registered provider. We saw that a screech alarm had been fitted that sounded if an internal door was opened via the emergency release mechanism. We heard that the alarm worked and there was a risk assessment in place for the new alarm system.

The home had a dedicated maintenance person who performs a variety of regular checks to ensure equipment was in good condition and safe to use, which included checking profiling beds and wheelchairs. They also checked the fire and hot water systems. These checks were recorded and should be signed off by the registered manager, however we saw they had not been for three months.

We saw information that showed that the registered provider had ensured that they had a valid gas safety and electrical fittings and fitments certificate in place. The nurse call had been tested in August 2017 and the passenger lift in October 2017 and hoists and slings in September 2017. The last Legionella test was carried out in March 2015 and the home was now doing water testing online but we were not clear if the online test met legal requirements. The checks of portable appliance testing (electrical items) was showing as ongoing. We saw that the home had an emergency contingency plan prepared by the operation director and approved by the registered provider. A contingency plan details the provisions in place in an event or circumstances which is possible to ensure service provision and safety of people who use services.

We saw that the service had been given a rating of 3 by the food hygiene rating scheme in September 2017, however the previous 5 rating was still being displayed on the window in the entrance to the home and also a copy of the previous rating was in the information available to visitors to the home. This was removed during our visit. The rating of 3 meant that improvements were needed to ensure the kitchen followed safe food storage and preparation practices. The registered manager told us that improvements had been made and they had asked for a revisit to the home.

We saw a copy of the service improvement plan (SIP) for continuous improvements to the premises dated 21 November 2017. We saw that this document had been updated regularly by the registered manager. This document highlighted concerns about the premises, for example there were problems with the roof that caused leaks when it rained. This situation had been ongoing since October 2016. The document also identified wooden window frames that needed to be replaced in Wembley House and also in the kitchen which added to concerns about the impact of infection control. In addition, there were concerns about radiator valves and some radiators needed to be replaced before winter.

We looked around parts of the building. We saw that in some areas of the home that tamper proof window restrictors were used. However, this was not always the case particularly in people's bedrooms. The Health and Safety Executive HSE guidance 'Falls from windows or balconies in health and social care', states that many reported accidents involve people in either a temporary or permanent confused mental state often caused by dementia and reduced mental capacity and provides advice on controlling risk and provisions to

be made which prevent windows from being opened to wide.

Arrangements were made to address this issue immediately and approximately forty restrictors were put in place. We saw that the home was subject to pest control. We saw that the boxes used to poison pests were visible and accessible in the dining room. There was no risk assessment in place. We were told that there was always a staff member supervising in the dining room when it was in use and when not in use the room was kept locked.

We saw information that showed what servicing arrangements were in place for fire safety, which included testing of the fire alarm, emergency lighting and fire extinguishers. We saw that the service produced and evacuation register often known as a personal emergency evacuation plan (PEEP). We saw this gave information to the emergency services about what support people would need to evacuate the building.

We also raised concerns about fire evacuation and safety in the stairwells. We saw a large commercial fridge freezer, which was in use in a stairwell because it was too big to fit in the kitchen. The fridge was moved following our inspection. We also saw holes in various parts of the ground floor ceiling, which suggested the compartmentalisation of the building that helps to prevent the spread of fire and smoke had been compromised.

We looked at a copy of the homes fire risk assessment which was on display in the entrance hall. A person qualified to do so had undertaken this on 13 April 2016. The fire risk assessment action plan showed that some of the issues we had found at our previous inspection had not been completed and photographic evidence was also provided. There was a completion date set for August 2016. We saw a review of the fire risk assessment dated 1 September 2017, undertaken by the regional maintenance director. However, the action plan on this document did not identify all the areas outstanding from the April 2016 fire risk assessment.

Following our inspection, we contacted the Greater Manchester Fire and Rescue Service. A fire officer visited the home on 6 December 2017. Following their visit, the fire officer issued the registered provider with a notice of deficiencies. The notice related to compartmentalisation issues that had been identified in the registered provider's fire risk assessment but still needed to be addressed. A programme of remedial works needed to be undertaken and prioritised this issue. Storage of combustibles were found in one of the escape routes near the laundry, these areas need to be kept clear at all times. The door to the laundry was wedged open and needed to be kept closed or fitted with a magnet lock, which closes the door on actuation of the fire alarm. A further visit will be undertaken by the fire officer to ensure compliance as part of their risk based inspection programme.

The shortfalls identified above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last focussed follow up inspection on 25 April 2017, we found that the home was in continuing breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the safe management of medicines. The overall rating for this key question was requires improvement.

Following the last inspection we asked the provider to complete an improvement action plan to show what they would do and by when to improve the key questions to at least good.

At this inspection, we checked whether improvement had been made to the management of medicines. The registered manager, deputy manager, nurses and two senior staff who had undergone two months of

supervision were authorised to administer medicines.

We saw that there was a treatment room, which was kept locked when not in use. There were separate medicines trollies for each floor, which were kept chained to the wall in the treatment room when not in use. The keys for the treatment room and medicines trolley were signed for at handover and not given to anyone else, except the registered manager who had overall responsibility for medicines management.

The treatment room had an electric cooler in place to keep it at the correct temperature and also a lockable medicines fridge. Records of room and fridge temperatures were maintained, however care needed to be taken to ensure the columns for both were not mixed up. If medicines are not kept at the right temperature, they can become less effective or unsafe to use.

We saw that the home had a medicines policy and procedure and the staff signature list was up to date. None of the people, who used the service at the time of our inspection visit, were assessed as being able to safely self-administer their own medicines. We saw on people's medicines records a Mental Capacity Act and Best Interest Checklist to help support the decision that had been made.

At our last inspection, we raised concerns about the lack of additional guidance being required on the PRN protocol when a person is prescribed medicine to be taken 'when required'. Although we saw improvements had been made additional information was still needed, for example, the use of distraction techniques such as talking to the person making them a cup of tea, were tried first and recorded so that medicines of this type were only used as a last resort. The registered manager added this information during our inspection.

The registered manager told us a number of people had been prescribed medication, which could be used 'when required' to help reduce their distress but that these were rarely if ever used. The registered manager said, "We don't use medication to sedate people apart from one resident who hallucinates and only if they are very distressed by the hallucinations do we use them." We saw detailed information on this person's behaviour care plan about how this person presented when hallucinating.

We examined the medication records for these people and we saw that they were not routinely being administered and one person had had the medication stopped by the General Practitioner (GP) as staff had said it was no longer being used and was no longer required. We also asked that the registered manager to contact the pharmacy to request clearer instructions on a person's Medication Administration Record (MAR) that suggested the medicine was prescribed as well as 'when required'. We noted that this medicine had not been recently used.

We saw that one person was prescribed a thickener, as they needed all their liquids to be thickened due to swallowing difficulties. The consistency required was written on their MAR. This reduced the risk of the person choking.

Three people were given their medicines disguised in food or drink. This had been agreed by their doctor after an assessment of their ability to understand the importance of these medicines for their health.

Controlled drugs, medicines subject to tighter controls as they are liable to misuse, were kept safely in a cupboard that complied with the law. We checked the stock balances of controlled drugs with the records and found that the quantities were correct.

We observed staff give people their medicines in an unhurried and safe way. At our last inspection we found that the application of people's prescribed moisturising and barrier creams by carers was poorly recorded.

This meant that records did not show if people's skin was cared for properly. Systems had been put in place where seniors checked this had been done at shift changes.

We saw that the Clinical Commissioning Group had carried out an assessment of the services medicines management systems on 8 June 2017 and produced a report. The report showed three recommendations were made which included clearer hand written signatures and making sure that any shortfalls in medicines were delivered in a timely manner.

We reviewed the personnel files of three staff members who had been recruited since our last inspection. We found the recruitment process was satisfactory and people had a full disclosure from the Disclosure and Barring Service (DBS) before starting work. A full employment history had been recorded and references from appropriate people received, with the exception of the nurse, where there were no references from previous employees. Where the file related to a nurse, a check had been made of the nurse's registration with the Nursing and Midwifery Council, the regulatory body for nurses and midwives in the UK.

We recommend that all recent recruitment files are reviewed to ensure that the service is meeting all the requirements of Regulation 19 Schedule 3.

All staff received training in safeguarding and this is renewed every year. There was a record kept in the registered manager's office of all safeguarding referrals that had been made to the local authority and CQC had been notified of these referrals in line with the legal requirements. The registered manager told us that they took overall responsibility for making safeguarding referrals but that staff were encouraged to make their own referrals too and then notify the manager in order to prevent delays.

We spoke with staff who demonstrated they understood the safeguarding policy and what they would do in the event they suspected anyone was at risk of abuse. Staff told us, "We will phone [the Local Authority Safeguarding Team] if there is an issue. We'd rather refer things when they happen over the weekend and evening rather than waiting." This means any issues were promptly and appropriately dealt with.

We saw that the designated nurse adult safeguarding lead for the clinical commissioning group (CCG) had carried out a thorough safeguarding assurance review on 21 November 2017. This listed actions needed to be undertaken to make further improvements to the current arrangements, the need for evidence of a number of policies and procedures, as well as positive comments. The registered manager was taking action to address these issues.

Staff told us they felt there were sufficient levels of staff on duty. They said, "We are fully staffed, we rarely use agency staff", "I'm happy with staffing, it's better now. [The registered manager] has improved it", "If we ever do use agency staff then we have a handover sheet and they also have access to the electronic care plans" and "We don't like using agency, they don't know our residents. We'd rather pick the extra shifts up ourselves." When we arrived at the home we spoke with two carers on the night shift. They confirmed that there was always a nurse on duty at night and five carers, one of whom worked between the two floors depending on people's needs. During the day we saw that there was a team leader and two senior on duty as well as ten care staff.

Throughout the inspection we saw staff were available for people and appeared unhurried. We observed staff to be frequently spending time speaking to people. Night care staff told us that they were under no pressure to get people up. They said they checked people every two hours. "If people are asleep we leave them and if they are awake we get them a cup of tea or encourage them to go back to sleep." They also told us that they were encouraged to think in terms of providing people with care over 24 hours to people rather

than distinction between nights and days. Two permanent nurses had been employed on nights, which had reduced the need for agency nurses. A new unit manager was also joining the team on the second day of the inspection.

We looked at the printed version of care records for four people who used the service who had different care and support needs. We saw that risk management plans were in place to guide staff on the action to take to mitigate the identified risks. Risk assessments had been completed for mobilisation and falls, oral health care, continence, malnutrition and dehydration risk and pressure area care.

Staff had received training in dealing with difficult behaviour and told us that they did not use physical restraint. A staff member said, "If someone is being challenging to us then rather than escalate the situation we walk away and try again later when they are less agitated. We talk to them rather than force them." The registered manager told us that on each floor of the home there were members of care staff who had received an additional three days training in a dementia diploma, infection control or health and safety and had become champions for their area of interest within their units.

We saw on the people's records a behavioural care plan that showed what methods were to be used to engage and how to distract and the person if they became agitated and disorientated. They also made reference to people's communication needs, for example, hearing loss, the impact of a noisy environment and encouraging people to wear their glasses.

The registered manager also told us that it was very important that both nurses and care staff had good communication skills. This was so they were able to engage and offer reassurance to people who lived with advanced dementia. The registered manager told us that they had taken action where staff were not able to demonstrate this during their probationary period.

The home appeared clean with no malodour in the parts of the home we saw. Records showed details of the daily cleaning tasks that had been completed and signed off on a daily basis. In addition, we observed members of care staff cleaning as required. We saw breakfast being served by staff wearing appropriate personal protective equipment (PPE). Sanitising hand gel dispensers were available in various locations throughout the home and we observed that staff used them regularly. All staff received training in infection control, which was updated regularly.

We visited the laundry, which was sited at Hilltop Court Nursing Home but also carried out the laundry for Hilltop Hall Nursing Home, which was on the same site. We saw that the home had new digital washing machines that had sluice facilities to wash soiled items at high temperatures. Red dissolvable bags were used to transfer these items to help prevent the spread of infection. This system could also use detergents that could kill bacteria at lower temperatures to reduce the risk of damaging people's clothes. We saw a chute was used from outside the home for the dirty linen washing bags from both homes to separate dirty washing from clean. From the quality assurance records we saw there were some staffing issues that needed to be resolved regarding staffing levels in the laundry. These were to be discussed with the registered manager at Hilltop Hall Nursing Home.

Good

Is the service effective?

Our findings

The registered manager told us that two members of the staff team visit a person to assess their suitability before they become a resident. A nurse or a member of the management team and a member of the care worker team usually carried out the assessment. This was to help ensure that they could meet both the needs of the person concerned and consider what impact their presenting behaviours may have on the established group. We talked about a recent admission to the home from The Meadows were the person had been presenting with behavioural management concerns. This person had settled well at the home and staff recognised that the person needed their own personal space and did not like to be disturbed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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 any conditions on authorisations to deprive a person of their liberty were being met. People had been assessed in line with the MCA to determine whether a DoLS authorisation was required.

Applications had been submitted to the relevant local authorities where appropriate and a record of this was kept. However, we noted from the record that of the 46 applications made only 19 had been authorised. This was because the local authority had triaged the applications as low priority. We saw that mental capacity was considered in all parts of the care planning process.

We looked at the care plan of a person who had no known family. We saw a court of protection care plan was in place that gave details of the person's solicitor and appointed social worker. The person had an independent mental capacity advocate (IMCA) in place. We discussed with the registered manager some of the presenting difficulties about reaching a best interest decision about whether or not to resuscitate the person should the need arise. This matter was ongoing.

The registered manager told us that all staff completed two weeks of shadowing experienced staff and induction training while their competency for the role was assessed. The registered manager explained that for night staff one week of the shadowing was done on the day shift while people were awake so they could get to know them.

Staff received training both face-to-face and online in areas such as safeguarding vulnerable people, moving and handling and infection control. Staff told us they felt they had received sufficient training before they started in their role. They said, "The induction was good."

We saw that the registered manager was able to access the online system to check whether staff had completed their training. A weekly report was produced that showed when staff training was overdue. Staff told us they received an email informing them when training was due. If they fail to complete the course on time then they are sent a letter and called to a meeting with a senior member of staff to explain why it has not been done.

If staff felt they needed training in any other areas they told us they would raise this with management and it would be provided. They said, "We get a lot of training but we can ask for extra. There is a list of available courses but if something isn't on the list we can ask for it" and "It's really good for training here, if we need it [the registered manager] will get it for us."

We were aware that The Lodge had recently become the registered providers head office and a training room had been created for staff from the three homes in the Stockport area to use. It was confirmed that staff received face-to-face moving and handling people and first aid training. Other training was online and there were plans in place for the online service to become more interactive in the near future. It was confirmed that regular agency workers also received induction training.

Supervision sessions were held with the staff member's immediate senior because they would know the staff members performance. The registered manager told us that an extra nurse was on duty one night a week so they could undertake supervision sessions with the night staff and review care plans. We saw a copy of the supervision tracker for 2017. This showed that some staff had not been involved in supervision sessions at all and many had only received one session. However when cross referencing the information against other records the information could need to be updated.

A person told us, "I must say, the food is bloody good. We get a choice; for breakfast it's porridge then a cooked breakfast or toast and jam or marmalade." The menu was on display throughout the home and changed every week. The menu offered a choice of meals. A new menu had recently been designed incorporating feedback from people who used the service. People had a light meal at lunchtime and their main meal of the day at tea time. This helped space out the food people received across the day and was also said to help people sleep. A tasting event had taken place in November for people and their families to try the new menu and feedback what they thought. The new menu had been well received and launched.

We observed breakfast being served. People were given a choice of where they ate. Most people chose to eat in the dining area but some chose the lounge or their bedroom. One person chose to walk and eat. Their choices were respected and supported. We observed that where people who needed assistance to eat they were supported to do by staff in a calm and patient manner. A staff member told us, "We have one resident who [because of her condition] will always refuse. We bring her both meals and she will choose which she wants."

We saw people being offered a drink of their choice, including a high-calorie homemade milkshake made from strawberries, whole milk and fresh cream. The registered manager explained that a high number of people were at risk of weight loss and so the milkshake was made to provide a more calorific drink than tea, coffee or juice. The calorific content had been calculated at 350 calories a glass providing extra calories for people who may be at risk of weight loss.

During the inspection we observed one of the senior care workers ask one of the care workers to complete a resident's chart. On investigation the senior care worker told us, "The care workers need to make sure the charts are fully filled in but the seniors check after every meal so any issues are picked up straight away."

People who used the service had the same doctor who visited the home every week. A list of people wanting to see the doctor was sent to the surgery before their visit but they would see extra people on the day if people wanted to see them. The doctor also reviewed people's medicines as required

If required, people were supported to attend hospital appointments with their key care worker. A staff member told us, "If one of the residents we are key worker for has an appointment then the rota is rearranged so we are not in the home but we get paid to accompany them to their appointment to make sure they are ok." During our inspection, we saw people being visited by an optician who was providing eye tests and helping people choose frames for their glasses.

We asked the registered manager about arrangements for dental care. The registered manager told us that people were registered with a dentist and had access to dental services in an emergency. The registered manager explained the difficulties people who lived with advanced dementia faced when visiting a dentist. The registered manager had made contact with a mobile dentist and it was intended that arrangements would be made for people to be seen in the familiar surroundings of the home.

Care plans made reference to people's illness and medical conditions such as type of dementia the person was living with, chronic obstructive airways disease, emphysema, age related macular degeneration and hypotension. Some staff had been involved in the React to Red training carried out by the clinical commissioning group (CCG) to raise awareness of pressure area care.

The home was bright and well-lit and in a good state of decoration. The downstairs communal lounge had recently been refurbished and had a variety of chairs of different styles and heights so people had a choice. The refurbishment of the upstairs lounge was planned and the upstairs dining area was to be decorated in the style of a pub snug. A relative commented, "It's spotless. It's looking lovely." The registered manager informed us each bedroom was redecorated before a new person moved in and that people were welcome to bring their personal belongings with them. We saw that there was dementia friendly furniture, which was easy to open and also space to put to outfits out so that people could choose what they wanted to wear.

Throughout the home there were a number of specially designed posters, which created the impression of it being a window with a three-dimensional effect looking out to different scenes such as the countryside or the sea. The registered manager told us, "We have a resident who will stand and stare at the posters and smile." We saw some well-presented memory boxes outside some people's rooms. The registered manager told us that some memory boxes had been taken down in some areas of the home as some people had banged their heads on them.

The home has a sensory garden, which people helped to maintain. There is a shed in the garden containing an old-style lawn mower and other tools, which staff said was particularly popular with the male residents. The home had won a Harbour Healthcare gardening competition because of people's involvement in developing it. The registered manager told us that one person had lost their confidence to go outside and so a piece of artificial grass, a deck chair and a garden gnome had been placed in the reception area overlooking the garden so the resident could still feel like they were in the garden but without feeling distressed.

Good

Is the service caring?

Our findings

We observed interactions between people and staff throughout our inspection. We saw numerous examples of staff treating residents with kindness. When we arrived at 7.15 am there were four people up and all appeared well dressed and cared for. As day staff came on duty they gathered in the communal area talking with people. One staff member sat next to a person and held their hand as they spoke.

A person told us, "They're very good here, everything is all right." Relatives said, "We've come to visit and see care staff sat talking to [relative]. Just because [relative] chooses to stay in their room sometimes and doesn't get left out. We wouldn't hesitate for another relative to be here. The staff are brilliant, they do amazing stuff" and "The staff are good. They're good and caring. They're very polite."

During our inspection, we carried out observations in public areas of the home and undertook a Short Observational Framework for Inspection (SOFI). A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We saw that there were good interactions between staff and people who used the service and staff were responsive to people's needs.

Staff told us they worked on the same unit all the time so they get to know people and this was better than moving between the different units. They told us, "I know how to approach people differently according to what they like." We heard care staff address some people more formally using Mr or Mrs and other people by their first names. A staff member said, "It's important to speak to the residents to get to know them and know what they like and find out what they want. If we know their life stories we can use them to take them back and make them smile."

Each person had a key worker who is responsible for ensuring they have enough toiletries and whether any clothing was becoming worn and needed replacing. If the person had no one else to replace the items then the member of staff would buy items for them. The registered manager told us that one person who had no family had been admitted to hospital. A rota had been drawn up to arrange visits by the care team to the person whilst they were in hospital. Care staff told us, "It's not just care that people get here; we're part of their everyday lives too."

The registered manager gave us a recent example of a person who did not celebrate Christmas but because of their dementia, they may not remember this and would see the Christmas activities and want to join in. The person was not able to understand the explanation and so the registered manager had discussed this with the person's relatives and agreed that they resident wouldn't be sent a Christmas card but if they wanted to join in any Christmas activities then they should be able to do what they wanted at the time.

To protect people's right to privacy we saw that information was securely held when not in use. We saw that the registered provider had a confidentiality policy and procedure, however it was noted that this policy needed to be updated and to include the use of the electronic records system, mobile phones and social media.

Good

Is the service responsive?

Our findings

The home used an electronic care planning system, which all staff had access to and could be updated at numerous locations throughout the home. Staff told us, "The electronic care plan is very good; it's far more detailed than paper." The electronic care plan included risk assessments of people as well as their daily notes section where observations could be recorded. This means that staff had access to up to date information about people available to them.

We looked at the printed version of care records for four people who used the service. We saw that information included a wide range of care plans, for example, safety and wellbeing plan, illness and medical condition care plan, mobilisation, personal care and physical wellbeing, skin care, sleeping, communication, daily life and social activities, elimination, behaviour, pain, a sexuality care plan, medication and oral health care plan.

We saw references to personal preferences on the care plans on the daily life and social activities care plan. This included how best to approach the person and talk about what their interest were, for example, how best to approach activities with the person and talk about their interests such rock and roll music from the 1960's and going for a walk around the grounds with a staff member if they became anxious or distressed.

The registered manager told us that where people had families they were involved in the care planning process and we could see this in some parts of the care planning process. However, it was difficult to evidence this because it was on the electronic system. All the care plans we saw had been reviewed within the past month. We saw information on the homes most recent internal key audit assessment that more development and training was needed by staff to complete care plans. This would help the registered manager to free up their time to carry out other management duties.

We observed the morning handover meeting between the oncoming day staff and the nurse from the night shift. We saw that the handover was thorough. The day staff team received an update about all the people who used the service. Any concerns about people were discussed and what action needed to take to support them. A written handover sheet was completed as part of the handover. We saw that the registered manager had put in place a carer's handover sheet. This gave carers a quick guide to people's mobility, continence, dietary and personal care needs.

We saw examples of staff demonstrating the knowledge they had of people's different choices and needs. A person asked for a cup of tea and the care worker replied, "You normally drink juice, you can have juice or we can get you a cup of tea if you like." The person chose tea and was given a cup of tea. On another occasion a person walked into a communal area and a staff member immediately identified they were wearing their night neck brace rather than their day one. The person was settled into the communal area while other staff fetched his day brace then he was assisted to change it. We saw nursing staff also had a good knowledge of the residents' needs. Staff told us, "It's important to get to know them, they are all different. You have to build the relationship with them."

We spoke with the activities coordinator for the home. They explained that a lot of people who lived with dementia would lose interest in formal activities. They said shorter activities, which would provoke a reaction were more appropriate. The activities coordinator told us, "You need a reaction as a stimulus rather than a task. I've got a snow globe with me today which I can give to the residents to interact with but often it's something silly like wearing a football shirt or bursting into song that will get a reaction from the residents." They said that the home had been adopted by the Alzheimer's Society who sent two activity workers every week to do activities with people and they had shared a lot of good ideas that could be used by the staff at the home.

The registered manager told us the home had adopted a donkey at a local donkey sanctuary, which made regular visits to the home and came inside so no residents were left out. They also had regular visits from a husky dog rescue centre that brought the dogs with them to interact with people and this had been very successful. There were also fish tanks around the building so people were able to look at and watch the fish. Visits from a professional singer along with karaoke sessions and a visit from a pantomime and carol singing had been arranged over the Christmas period. Professional musicians from the Music in Hospitals and Care group also visited the home.

We saw a copy of the homes newsletter the Hilltop Court Herald. This gave information and pictures about activities that had taken place in October and events being held in November 2017 for example, a folk duo with a buffet, a firework display, a poppy themed craft session for Remembrance Sunday, trips out in the minibus and a celebration of St Andrew's day.

The registered manager told us that one person preferred to stay in their room rather than spend time in the communal areas. They explained, "[Person] likes her space so it's in her care plan to leave her alone if she's in her room. She has a key so can come and go."

The activities co-ordinator had recently reduced their hours and a second activities co-ordinator had been identified within the care staff team. They were undertaking a three day health and safety training to enable them to drive the mini bus. The registered manager told us that it was expected that care staff would spend at least one hour a day with each person, spending time chatting and reading to them.

The registered manager told us and records supported that all staff at the service had all recently attended the Six Steps training programme to support people who were nearing the end of their life. We saw that there were death and dying care plans in place on people's files. The registered manager attends the quarterly end of life forum meetings. This gave the registered manager the opportunity to share best practice and ideas. We saw a copy of the new care plan to be introduced titled, 'What If Celebrating My Life.'

We saw that the service had a complaints policy and procedure. How to make a complaint was also available in the homes statement of purpose. We reviewed the complaints log for the home. We saw that there had been seven complaints recorded from April 2017, from relatives, staff and other professionals. The registered manager kept detailed records about what action had been taken to resolve the complaints.

Requires Improvement

Is the service well-led?

Our findings

At this inspection, we raised concerns about a number of identified health and safety issues that had not been actioned. This meant the registered provider's quality assurance systems were not effective.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. This ensured they provided people with a good service and met appropriate quality standards and legal obligations.

We saw a copy of the service improvement plan (SIP) for continuous improvements to the premises which was dated 21 November 2017. We saw that the registered manager had updated this document regularly. This document showed that there were ongoing problems with the roof, which were first identified in October 2016, that wooden window frames needed to be replaced in Wembley House and in the kitchen, with added concerns about the impact of infection control in the kitchen, as well as radiator valves and some radiators needed to be replaced before winter. All these areas were listed as ongoing.

We saw that the care quality lead had undertaken an assessment entitled Key Outcomes Audit on 7 and 8 November 2017. The areas covered included care and support, the environment, staffing and management and leadership of the home. The home had been rated by the care quality lead, as overall adequate and showed a number of shortfalls at the service. These included record keeping and improvements needed to person centred care planning. The registered manager told us that they had disputed the rating and did not agree with all the overall score. The leadership and management of the home was rated as good.

We saw a copy of the homes service improvement plan (SIP). which had been updated on 27 November 2017. The SIP gave information about areas of concern at the home and was kept under review and updated by the registered manager. Areas included in the SIP were a problematic telephone system, concerns about the presentation of pureed diets and the need for food moulds, evidence for one to one activities that take place in people's rooms, problems with laundry staff shortages and sharing domestic staff with Hilltop Hall. We could see any new areas of identified concerns being added to the SIP for monitoring. We also saw a copy of an internal support visit report undertaken on 23 March 2017 that carried out a dining services audit and observation, which recommended a number of actions and also a business development audit which rated the service as an acceptable 76 percent.

The registered provider's quality assurance systems had identified health and safety and quality concerns. However, there had been a delay in taking action to resolve these issues. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a manager who had been registered with us since August 2015. The registered manager was a Registered General Nurse (RGN) and Registered Mental Health Nurse (RMN) and had also completed a law degree. They had worked in nursing and social care setting for forty years. They also had personal experience of a relative living with dementia in a care home. We saw that the registered manager attended

the Stockport Focus Group for care homes. This gave the registered manager the opportunity to share ideas and concerns and discuss best practice.

The registered manager informed us that they thought in their time at the home they had improved the need to recognise people who lived with advanced dementia as individuals. They had also looked at new ways to support people with behaviours that challenge others without the use of sedation, and provide short bursts of interaction with people to stimulate responses from them, rather than longer activities.

The registered manager was in the process of strengthening the management team, but had had difficulties finding the right staff. The deputy manager left the service shortly after our inspections and the two unit managers were both new to the service. Seven carers were in the process of becoming advanced practitioners. These are care staff who are undertaking additional training to help support the registered manager and nursing staff.

Talking to staff we heard numerous examples of where the registered manager had taken steps to look after their well-being when they had issues outside of work. Staff said, "If we need help we can go to [the registered manager] with anything, she will help", "They're really good, they're really supportive", [The registered manager] is amazing" and "She's brilliant."

We found the culture of the service was very open with people, their relatives and staff all saying they would have no problem with raising issues with the manager or other staff.

We spoke with relatives of residents who told us, "Staff are really approachable, we'd have no concerns raising any issues" and "The nurse has told us that after we have finished visiting if we want to talk to him about anything he'd be happy to." Staff said, "We work as a team. If we don't communicate the residents won't get the best care and get looked after."

We saw that the manager on duty completed a daily walk round of the home and also attended the 8.00am handover. This helped them to gain oversight of what was happening in the home and address any concerns that were raised.

Staff had access to an 'app' on the mobile phones so they could access the registered provider's policies and procedures at all times. All staff were expected to attend staff meetings unless they were off sick. The last full staff meeting took place on 15 November 2017 and nurses meeting on 18 October 2017. Health and safety meetings were also held.

The service held relatives meetings however, despite the registered managers keenness for them to become involved in the home, these were not well attended. The next relatives meeting had been arranged for 3 December 2017.

We did see thank you cards from relatives on display, stating, 'Thanks for all your wonderful care of [relative] over the past four years', 'Thank you all for doing such a marvellous job in looking after our [relative] for the last two years. We do apologise the [behaviour] and really appreciated you treated [relative] with the utmost dignity and respect' and "There are no words to express the deep felt thanks. Your dedication, kindness, knowledge and spirit have been a blessing to our family. Thank you for all you have done."

We saw that the last rating for the home was displayed in the reception area along with a full copy of the report. Before our inspection, we checked the provider's website, which also gave the current rating of the home.

We saw copies of the services statement of purpose and service user guide. The statement of purpose is a legally required document that informs people what they should expect from the service. Both documents had been kept under review by the registered manager.

Before our inspection, we checked the records we held about the service. We found that the registered manager had notified the Care Quality Commission of any accidents, serious incidents and safeguarding allegations, as they are required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were kept safe.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance arrangements. Regulation 12 (2) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Although systems were in place to identify risks to health and safety, action to mitigate the risks had not been taken in a timely manner. Regulation 17 (2) (1) (c)