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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 31 August 2016 and 1 September 2016. The service was last inspected on 28 October 2014. This was a follow up inspection and the service was found to be compliant.

Hilltop Court Nursing Home provides accommodation for up to 50 people who were living with advanced dementia. There were 44 people living in the service on the day of our inspection. We were not able to speak to people who used the service to ask them questions due to the nature of their diagnosis and lack of capacity. We therefore spoke with relatives and staff members and undertook observations around the service.

The service had a registered manager in place at the time of our inspection. 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.

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

Medicines were not always managed safely. This was because the administration of medicines was not always as prescribed, there was a lack of information available to staff on medicines that were to be taken 'when required' and one person was self-administering one of their medicines despite lacking capacity and with being risk assessed. We also checked controlled drugs within the service. A large surplus of one medicine could not be accounted for.

Staff members told us that although sometimes they felt as though there was not enough staff, they always managed to meet the needs of people who used the service.

We found risk assessments were in place in relation to the environment and possible hazards. Care records we looked at showed that individual risks to people had also been considered and protective factors identified to keep people safe.

Recruitment processes and systems in place within the service were robust. This meant that people who used the service were protected against the risk of unsuitable people working within the service.

We saw no evidence that nursing staff had received clinical supervision. The managing director could not tell us if these were being completed and the registered manager was not available to ask. We have made a recommendation that the service considers clinical supervisions for all the nursing staff.

Records we looked at showed that people had been assessed in relation to their capacity. These assessments had been undertaken by the relevant and appropriate people and had involved the person and their family. We also saw that best interest meetings had been undertaken for those people who lacked capacity to consent.

DoLS applications, which CQC should be made aware of, had been notified to us in a timely manner. We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body.

We checked the kitchen and found adequate supplies of fresh, fresh, tinned and dried food was available. The service had a 5* rating from environmental health. All the relatives we spoke with told us the food was good. We have made a recommendation that the service considers current best practice guidance in relation to supporting people with advanced dementia during mealtimes.

Activities on offer within the service included, film night, board games, armchair exercises, 'news and natter', arts and crafts, entertainers, afternoon tea, karaoke and pyjama days. We observed one person was sat in the garden with their relative enjoying the good weather.

We looked at a number of policies and procedures during our inspection. We found these were robust and would support staff members in their roles.

Regular residents and relatives meetings were held in the service. One was being undertaken on the day of our inspection which we attended. We saw people and their relatives were given the opportunity to comment on the service.

People were given documentation called a Service User Guide when they were admitted to the home and a copy was available on the entrance notice board. This gave people a welcome to the home statement and informed them of the philosophy of care.

The registered manager told us they sent out questionnaires to relatives as a means of gaining feedback about the service.

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.

Medicines were not always managed safely within the service.

Staff members knew their responsibilities in relation to safeguarding. They were able to tell us how they would respond if they had any concerns for the safety of people who used the service.

The service had an infection control policy in place. Staff had been trained in infection control and were aware of their responsibilities.

Is the service effective?

Good

The service was effective.

People who used the service had access to external healthcare professionals such as GP's, district nurses, dieticians and chiropodists.

Prior to our inspection we reviewed our records and saw that DoLS applications, which CQC should be made aware of, had been notified to us in a timely manner.

Relatives we spoke with told us the food at Hilltop Court was good and there was always a choice.

Is the service caring?

Good

The service was caring.

People's care records were stored confidentially and only people who needed to have access to them could.

We observed interactions from care staff members that were kind, caring and sensitive.

We observed that staff respected people's privacy and dignity; staff knocked on people's door before entering and doors were closed when people were being supported with their personal

care needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people's personal preferences or direct staff in their role. Care plans were not easily accessible to staff.

The service had a complaints policy and procedure in place which was given to people who used the service and their relatives. The registered manager had dealt with any complaints in line with this policy.

We saw a range of activities were on offer on a daily basis. These were specifically designed to stimulate people who were living with advanced dementia.

Is the service well-led?

Good

The service was well-led.

The service had quality assurance systems in place and these were sufficiently robust to identify areas for improvement.

Accidents or incidents that should be reported to CQC had been done in a timely manner.

Relatives and staff members told us the registered manager was approachable and supportive. The registered manager had a visible presence within the service.

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.

This inspection took place on 31 August 2016 and 1 September 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors on both days and a pharmacist inspector on the second day.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We received this prior to our inspection and used the information to help with planning.

We contacted the local authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The local authority safeguarding team provided us with information about the service that was taken into consideration when planning this inspection.

We were unable to speak to people who used the service as they were living with advanced dementia and were not able to answer our questions. We spoke with five relatives to gain their views on the service. We also spoke with one nurse and two care staff members, the cook, the deputy manager, the registered manager and the managing director.

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

We looked at the care records for four people who used the service and a number of medicine records. We also looked at five staff personnel files and a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We looked at the way medicines were managed and talked to the managers and nurses on duty. One nurse told us "I have confidence in the home's managers who are good and making the use of medicines safer". Another agency nurse told us, "They audit the medicines and they checked my competency when I started." The home carried out its own medicine audits and no issues had recently been identified.

We watched six people being given their medicines and saw that nurses gave medicines in a respectful and friendly way. A newly appointed nurse was being supervised to check they handled medicines safely. We looked at the medicine charts belonging to 25 of the 44 people living in the home and found very few 'gaps' in the records of administration. Nurses working on different floors of the home checked each other's medicine charts to much sure everyone had received their medicines. People's allergy status was recorded to prevent them being given a medicine that had previously harmed them, by mistake. The special instructions kept with each person's chart stated if a person needed all their liquids thickened, and the consistency required, to stop them choking.

One person was prescribed a medicine to treat an infection for three days but the record on their chart stated it had been given for five days. Another person had not received one of their morning medicines as the nurse thought it was out of stock. When we asked about this the medicine was found and administered. Dose instructions for a person's dispensed eye drops were incomplete and the record on their chart stated that only three out of 15 doses had been administered.

Some people were prescribed a medicine to be taken only 'when required'. Extra information (in the form of a protocol) to guide staff as to when the medicine was needed was available for some people, but not others. If staff have insufficient information on why the doctor has prescribed a medicine 'when required' the person's health and well-being is put at risk. The application of creams to people's skin was mostly documented well, showing that people's skin was cared for.
One person was given medicine for pain relief, in the form of a patch placed on their skin, one day early because records on the person's medicine chart and in the controlled drugs register were incomplete and unclear. We brought this to the deputy manager's attention.

Another person was self- administering their medicine for breathlessness and kept the inhaler in their pocket. The nurse told us that this person had limited capacity to understand how to use medicines safely. The person's care plan (updated in July 2016) stated that a nurse administered the medicine and no risk assessment for self-administration was recorded. This situation put the person themselves and other people living in the home at risk of harm.

Medicines were kept safely and at the right temperatures. Medicine cupboards were clean and tidy. We checked the stock levels of controlled drugs with the records and found a large surplus of one liquid medicine that could not be accounted for. The discrepancy had gone unnoticed because nurses had not carried out a stock check of controlled drugs since the end of June 2016.

These matters are a breach of Regulation 12 (1) and (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always managed safely.

Relatives we spoke with told us, "I have never seen anything to feel [my relative] was not safe", "I think she is safe here" and "I would say something if I did not feel it was safe here." Two staff members told us, "I would definitely report any poor practice although I have not seen any. If they did not listen to me here I would go higher" and "I am aware of the whistleblowing policy and would use it. If it was the registered manager I would go higher up to the operations manager, local authority or Care Quality Commission. I know it is my responsibility to follow it up. I have completed my safeguarding training so know what to do." An agency nurse we spoke with was aware of the types of abuse and said she would report any issues to the registered manager. Records we looked at confirmed that staff had received training in safeguarding.

The service had a safeguarding policy in place. This looked at legislation, defining abuse, preventing abuse from occurring, identifying actual or possible abuse and procedures for when abuse had occurred. This should ensure that staff felt confident when reporting or acting on any concerns. We observed that safeguarding information was also available in communal areas of the home for people who used the service, staff and visitors. An easy read poster was displayed, "Speak up to stop abuse". This provided information on who to contact if anyone had any concerns in relation to the safety of people living at Hilltop Court Nursing Home. The service also the numbers of the RMBC safeguarding team for staff to follow a local initiative. There was also a whistle blowing policy in place. A whistle blowing policy protects staff who report poor practice or abuse in good faith.

We looked at the systems in place to ensure staff were safely recruited. We reviewed five staff personnel files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The service also had a recruitment policy in place to guide the manager on safe recruitment processes.

An agency nurse told us, "They have permanent staff and I think they usually have enough staff. If not they use the same agency staff. "Two staff members said, "I think we are a little understaffed sometimes but we can meet people's needs" and "There are enough staff to meet the needs of the people and we have systems to replace them. Agency and bank staff." We looked at two weeks off duties and saw that there were two nurses on the day shift, eight care staff, the administrator, two domestic staff, two cooks and a kitchen assistant, a handyman (on leave) and a person worked in the laundry. There was a trained nurse and four care staff who worked nights and also a person worked in the laundry during the night. Staff were supported by the registered manager and the deputy manager. Staff and relatives told us the deputy manager was very 'hands on'.

We looked at a number of operational risk assessments that were in place in the service including, scald/burn from running hot water, moving and handling, lone worker, poor lighting outside the home, chemical burns/ingestion, furniture or other items blocking a fire door and aggressive behaviour. All showed that consideration was given to how people might be harmed, what the service was doing to reduce the risk and any further action that was needed. This should help to ensure that people who used the service, staff members and visitors were protected against any risks within the service.

Care records we looked at contained risk assessments. These were in relation to assessing risks if people had problems with certain aspects of their health, such as a history of falls, pressure ulcers, poor nutrition, choking, urinary incontinence, oral health and personal care. We also saw risk assessments were in place for

those people who required a hoist to assist them to move, walking frames and bed rails. We saw these were reviewed on a regular basis to ensure they remained relevant.

We saw there was a system for staff to report any faults or broken equipment. The maintenance person signed off any work that had been completed and this was checked by the registered manager. There was also a booklet the maintenance man had to complete monthly for environmental checks and this was audited by the registered manager and another senior member of staff.

During the tour of the building we checked that windows had a restricted opening to prevent accidental falls and the water outlet temperatures and radiators were safe. Apart from one sink which was too hot we found they were safe for people to use. The registered manager said she would get the maintenance man to fix it. We noted they were checked regularly by the maintenance man and the registered manager audited his work. We saw that the maintenance man took photographs of any equipment he found needed replacing or repairing.

We saw there was regular maintenance by external professionals. This meant the electrical installation and gas equipment was safe. We also saw documentation for the lift, hoist and sling checks, the control of Legionella and portable appliance tests (PAT). This meant equipment was safe for staff and people who used the service.

There was a business continuity plan to inform staff of how the home could function with a loss of facilities such as gas, electricity or bad weather. Part of the plan was to show the arrangements that could be made for looking after people if the home could not function to help keep them safe and continue with their care. This meant people could be found another home to keep them safe.

There was an emergency 'grab bag' located near the entrance which contained a personal emergency evacuation plan (PEEP). This plan was available to hand to emergency services and told them what support each person needed to leave the building safely. There was also specialist equipment to use for example a mattress to get people down stairs. There was a fire risk assessment with a contingency plan for the safe movement of people to another facility if needed.

The fire alarm and call bell system was also checked periodically to ensure they were working correctly. There was a record of fire drills with staff being taught evacuation of the premises and the fire break points were checked on rotation to ensure they were working.

Accidents and incidents were recorded and the registered manager audited them to see if they could minimise any risks identified. This helped protect the health and welfare of people who used the service.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. There was an infection control policy in place to guide staff in the prevention of cross infection, rules to prevent the spread of infection, blood borne viruses, outbreak control measures, clinical waste, skin infections and recording. At the last local authority infection control audit the service achieved a good scoring of 89%. We saw that where improvements could be made the registered manager had developed a plan to do so.

The laundry was sited away from food preparation area. We went into the laundry during the tour of the building and noted there were three dryers and four washing machines. This was sufficient for the people accommodated at the home. There was an automatic system for adding the detergents. Washing machines had a sluicing facility and the service used colour coded bags for contaminated laundry and waste. There

was a system used where dirty laundry came in, was washed and put separately to avoid cross contamination. The registered manager said whilst the machines were working they were getting unreliable and there were plans to upgrade the laundry. One relative did tell us, "There is a problem with clothing. There are problems losing it or putting it in the wrong rooms There are dedicated laundry staff so why?" This problem was addressed at the relatives meeting with the registered manager who would look at ways of improving the laundry service. We also saw the service had invested in a tagging system to prevent clothes from getting lost although we were told not all families wanted to use them.

Staff had access to hand wash gels and paper towels. Staff were also provided with personal protective equipment, which we noted was used when giving personal care or serving food. There was a system for the disposal of contaminated waste.

Good

Is the service effective?

Our findings

Two staff members we spoke with said, "I think there is sufficient training to do the job, I have asked for more training and they have provided it. I completed a course – a diploma in health and social care. Off the top of my head I have also completed training for food hygiene, health and safety, COSSH (safe usage and storage of chemicals), dementia care, moving and handling, infection control and safeguarding. I am a fire marshal and also a COSSH champion" and "I completed an induction when I started here and was supported until I was confident to work with the people accommodated here. I have also completed training for fire safety, health and safety, policies and procedures, safeguarding, moving and handling, first aid, infection control and I am currently completing food safety. I have the level 2, 3 and 4 diploma in health and social care. I think I have done enough training to be competent to carry out my job. You can also ask for any you think you need."

We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Hilltop Court Nursing Home. We spoke with the manager, staff and examined training records to see what training opportunities had been made available.

Some new staff were employed as apprentices via the local college and were completing qualifications in health and social care. This meant they were supported and trained by college staff. Other staff directly employed by the service were undertaking an induction using the documentation and compact discs for the care certificate which is considered best practice for people working for the first time in the care industry. All staff were shown around the building to acclimatise themselves to the fire escapes and facilities and had to sign for the staff handbook, which informed them of what constitutes good care. New staff told us they were supported by an experienced member of staff until they felt confident to work upon their own.

We looked at the training matrix and saw courses for staff included control of substances hazardous to health (COSHH), MCA, first aid, fire prevention, infection control, safeguarding, dementia, dignity in care, manual handling, bathing and grooming, bowel management, assessing risks, oral hygiene, customer service, documentation, person centred care planning, bullying and harassment, duty of candour and administering injections.

The service also had champions in place in relation to certain subjects, for example there were two dementia champions, two nutrition champions and two COSHH champions. These people had received enhanced training and were available to support their colleagues if any issues arose and they required support. The registered manager sourced the in-depth courses on the subject's staff members were interested in.

One nurse and two care staff thought they were supervised and supported in their work. We looked at the supervision and appraisal records for approximately 30 staff. Items highlighted at previous meetings were discussed to see how staff were progressing. Any new items were brought to the supervision session and included staff training needs and training completed. Both the manager and staff member signed the forms. We saw examples of where staff needed training this had been completed but supervision also gave staff the

opportunity to say what they thought were their strong points. Where performance was not as good as was wanted staff were put onto improvement plans to help them gain the necessary skills. We did not see evidence that qualified nurses received clinical supervision. The managing director was unsure if nurses did have clinical supervision and the registered manager was not available to ask. Clinical supervisions allow nursing staff to discuss their clinical practice, current good practice guidance and any development needs they may have. We recommend the service considers regular clinical supervisions for all their qualified nurses following best practice guidance.

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 interest and as least restrictive as possible.

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 any conditions on authorisations to deprive a person of their liberty were being met.

Prior to our inspection we reviewed our records and saw that DoLS applications, which CQC should be made aware of, had been notified to us in a timely manner. We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body (local authority).

Records we looked at showed that people had been assessed in relation to their capacity. These assessments had been undertaken by the relevant and appropriate people and had involved the person and their family. We also saw that best interest meetings had been undertaken for those people who lacked capacity to consent. A 'best interest' meeting is where other professionals, and family if relevant, decide the best course of action to take to ensure the best outcome for the person using the service. We saw that the service had involved external health professionals in their decision making process and acted in the best interest of the person being assessed.

During the registered manager's daily walk around the service staff are prompted to explain what they understood capacity to be, what they thought informed consent was, to explain DoLS and safeguarding. This showed the registered manager was committed to ensuring that staff members understood their roles and responsibilities in this area.

The care records showed that people had access to speech and language therapists, GP, dentists, opticians and chiropodists. This meant that the service was effective in promoting and protecting the health and well-being of people who used the service.

During the lunchtime meal service on the second day of our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Tables had cloths on them and napkins were available. We saw the crockery used in Hilltop Court was blue. Research suggests that crockery in blue, red or green set against a contrasting tablecloth supports people living with dementia to identify their meal. This meant the service had considered the needs of people who used the service to maintain their independence in taking a healthy diet. However, the menus in place

within the service were not dementia friendly and were just a printed list of choices. Staff members did not show people who used the service the choice of lunchtime meals but people were asked. Showing people the choices available to them promotes independence and allows people to make an informed choice. We recommend the service considers current best practice guidance in relation to supporting people with advanced dementia during mealtimes.

We saw that some people came into the dining room for their meal and other people chose to eat in the privacy of their own rooms.

Relatives we spoke with told us, "I come every day at lunch time and I give my relative lunch. The food seems to be good. It is substantial and there is a choice", "The food is good. I have seen it when I visit" and "The food is pretty good. They are giving him fortified food to help him keep his weight up."

At the last environmental health inspection of the kitchen (March 2016) the service were awarded the five star very good rating which meant the cooks followed safe practices of ordering, storing, cooking and serving food. This meant the service also had good systems to keep the kitchen and equipment clean.

We saw that there was an option at meal times. The cook said people were able to have a full breakfast every other day and other breakfast foods on the other days. This included options such as eggs on toast and cereals or porridge. There was a lighter lunch and a main meal in the evening. We saw that there was a varied diet with a choice at every meal time. We saw people were asked what they wanted at each meal and the choices were displayed in the dining room.

We visited the kitchen and saw there was a good supply of fresh, frozen, dried and canned foods in the stores. The cook said people who used the service were particularly fond of smoothies made with fresh fruit and fortified with cream. It was calculated that each drink contained 500 calories to help keep up the weight of people who may not be able to concentrate to eat a meal. The cook also said they had no problems ordering the supplies and always had plenty of stock. They told us the main supplies arrived twice a week and fresh foods were delivered daily.

There was a record of the diets people were on in the kitchen, for example fortified meals or for people who had diabetes and a record was taken of each meal for kitchen staff to follow an audit trail if needed. We saw that tables were set with plastic table cloths at breakfast and lunch but had linen table cloths in the evening.

Hilltop Court provided care and support to those people living with advanced dementia. We saw there was dementia friendly signage throughout the service to direct people to bathrooms, toilets and lounges. We saw there was a memory box outside each person's room, most of which contained personal memorabilia, such as pears soap, sewing needles, war memorabilia, pictures and photographs, so that people could recognise which was their bedroom.

At the main entrance to Hilltop Court we saw an area which had been dressed to represent a garden area. There was false grass, plant pots, artificial trees and other gardening items to give the feeling of being outside. The registered manager also told us they had deck chairs for people to sit in. We saw there were hooks in communal areas which contained hats, scarves and handbags that people who used the service could pick up and wear. There were wall hangings which were textured or contained locks and bolts for sensory stimulation. We saw one person was walking around with different scarves and handbags throughout our inspection and we saw a number of people sat in the main entrance area.

Relatives we spoke with told us, "They have given her a bigger room. She is sleeping better. It is always clean

and tidy and does not have a nasty smell", "My relatives room is lovely and it has been personalised" and "The room is basic but it is clean and we could dress it up more ourselves. There are some items which are personal."

On the top floor the registered manager showed us the newly completed dining room. They explained that a bedroom had been removed and the space used to make a larger, more spacious dining room. The dining room had been decorated but the service was awaiting local students to come in and paint murals on the walls that would assist people to recognise this was a dining area.

The registered manager showed us bedroom furniture that had been purchased for all the bedrooms. Wardrobes and drawers did not have handles but cut out sections where people could just pull the drawers out or open the doors to make it easier to access. There was a section at the side of the wardrobe without a door where a choice of clothes could be placed so that people could decide what they wanted to wear for the day. This promoted independence and choice for people who used the service.

Good

Is the service caring?

Our findings

Relatives we spoke with told us, "Staff are very kind to our relative and welcoming to us as well", "My relative has been here three years and the staff are pretty good at looking after her. Very caring. I come at different times every week", "The staff are very good - they are brilliant. The nurses are also brilliant" and "Care staff are friendly and helpful. Staff are good and treat people well. Facilities are not as good."

Two staff members told us, "I am happy working here. I like working for the residents. I think I know them very well. I would be more than happy for a member of my family to live here if they needed care" and "I would be happy for a member of my family to live here. I love working here."

We observed that staff members' approach was calm, respectful and valued people. They explained options and offered choices using appropriate communication skills. People appeared comfortable and confident around the staff.

The registered manager and deputy manager had already been trained in end of life; the registered manager told us they were booked on an update course in the 'six steps end of life care' training at the local hospice in the near future. This training aims to guarantee that every possible resource is made available to people in order to facilitate a private, comfortable, dignified and pain free death.

Relatives were offered and some took up end of life care sessions provided by staff members who were able to pass on knowledge from their own training. This would help them prepare and be supported with decisions they needed to make if their family member accommodated at the home deteriorated. Most of the people who lived at this care home had advanced dementia and needed this support from people who knew them well and would ensure their wishes were known at the end of their life.

Records we looked at showed that some people had end of life care plans in place and others did not. We mentioned this to the managing director and the deputy manager who assured us they would address this and include it on their action plan.

We observed that staff respected people's privacy and dignity; staff knocked on people's door before entering and doors were closed when people were being supported with their personal care needs. We found the atmosphere in the service was warm and friendly. We saw that staff had time to sit and talk to people who used the service. We observed call bells were answered in a timely manner and people were not rushed.

There was a confidentiality policy which informed staff of how to protect information. This included not using public media to discuss work related topics. Documents we observed were all stored in a locked office to help maintain confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Prior to admission the service asked families to complete an 'about me' assessment tool. This covered areas such as important people in the person's life, important dates, items that were important to them, family history, education, life history, significant life events, communication (how the person communicated and any support they required), sensory needs, how they like to spend their day, how the person wished to be supported when they were unhappy or upset, the time the person liked to rise in the morning and retire at night, morning routines, evening routines, personal care preferences and the level of support required, food and drink preferences including any allergies, hobbies, interests and favourite past times, favourite music/television shows, newspapers and magazines, places of interest, bedtime preferences, my religious beliefs, needs and wishes, advanced care planning and additional areas of support such as family. This amount of information is helpful when planning care for those people with advanced dementia, to ensure that the service can meet their needs. The registered manager told us the service was in the process of switching to electronic care records and that not all the information required had been transferred to the new system. We noted this and were told updating the system was ongoing.

We looked at the electronic care records for four people who used the service. Some care plans contained detailed information to guide staff on the care and support to be provided. There was good information about the person's social and personal care needs. People's likes, dislikes, preferences and routines had been incorporated into their care plans, such as likes a cup of tea or Horlicks before bed, likes to wear a nightdress when going to bed and likes a shower weekly. This showed a person-centred approach to providing care. However, some care plans we looked at lacked information and direction for staff members. We also found that due to the system changing staff did not have easy access to care plans in order to keep up to date with changing needs of people who used the service. We discussed this with the managing director and deputy manager who informed us that in the near future there would be numerous iPad's available for staff so that they could access the care plans easily and when required. Until such time, this meant staff did not always have access to information to guide them in their roles when providing support and treatment to people who used the service.

During our inspection we also looked at how the service addressed people's religious and cultural needs. We saw the activity planner mentioned holy communion visits and visits by ministers/priest, however there was no evidence to show which people would like to attend or if these needs were considered.

None of the care records we looked at included a care plan to ensure people's religious or cultural preferences were addressed. This meant care staff members had no way of knowing if the person was religious or how to meet their religious needs. End of life care plans did not highlight what religion, if any, the person was or what their religious wishes/needs may be at the time of their death.

These matters are a breach of regulation 9 (1) and (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment of people who used the service did not always reflect their preferences and care plans were not always available to all staff.

Each person and their families were given a copy of the complaints procedure when they were admitted and there was a copy available for people to access in the entrance hall. This told people how to make a complaint, who to complain to and the time they would have their concerns responded to. We saw there was evidence the registered manager followed the procedures, audited the complaints and responded where necessary. The contact details of the local authority and Care Quality Commission were included in the procedure for people to take their concerns further if they wished. Relatives told us, "I put a complaint in and it did get sorted eventually", "The new manager is more approachable. I think I can talk to the manager and could talk to her about any concerns" and "If I was concerned I know they would listen to me."

Relatives we spoke to told us, "We looked at other homes and we were given the choice to come here. They phone you up if anything is wrong. One of the nurses usually", "We looked at several places and chose here. It suited us better. They keep me up to date with any care issues", "They do not always let me know when something has happened. I visit every day and I would prefer to be kept informed. I have addressed it with the manager and have confidence it will be sorted."

Two staff members we spoke with told us, "We have staff meetings and can discuss any issues such as the facilities, training or routines. You can also bring up issues as a key worker. We have daily handovers to let us know what is going on. At the moment junior staff cannot access care plans. Only seniors can log into it. I think it would be useful to look at them" and "We are kept up to date at handover meetings for resident's and meetings for everything else."

The service had an activities co-ordinator in place but they were not available during our inspection. Relatives told us activities were held regularly and they were able to join in with their families and staff.

We looked at the notice board in the entrance of the service and saw a weekly activity plan. Activities on offer included, film night, board games, armchair exercises, 'news and natter', arts and crafts, entertainers, afternoon tea, karaoke and pyjama days. We saw themed celebrations took place throughout the year such as St George's Day, Mother's Day, Easter, Christmas Fayre, Hilltop Court's got talent, Halloween – pumpkin carving, Halloween cake baking and Halloween themed tea and a Firework display on bonfire night. Records also showed that the service provided dog therapy; huskies were brought in by an external agency. The registered manager told us people who used the service got a great deal of satisfaction from their visits and they were always well received.

We saw a person was sat in the garden with a relative making use of the facilities in the good weather and staff sat taking time to chat with people.

Good

Is the service well-led?

Our findings

The service had a registered manager in place at the time of our inspection. 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.

Relatives we spoke with told us, "My relative is happy. When he came out of hospital his face lit up and we could tell this was the right place for him. I am happy with the care. The deputy manager will talk to us if we have a problem", "I am happy with the care overall. I would cause a big stink if it was not good. You can approach the manager and she will listen. So will the unit manager", "The manager seems to lead the team well. I contribute to the magazine and I attend the meetings. My daughter who is a professional is happy with the care here and so am I" and "I think the manager was defensive when I have approached her although the unit manager listens to me." Two staff members said, "The managers are approachable and supportive. If you need anything just ask and most of the time you get it" and "The manager is approachable. They deputy is amazing and gets out onto the floor and gets stuck into care."

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

We looked at the quality assurance systems in place within the service and found that these were sufficiently robust to identify areas for improvement. The audits we looked at included monthly care plans, dining services audit and observations, fall prevention, infection control, pressure ulcer, annual key outcomes, business development, regional managers monthly compliance visits, maintenance review, quarterly safeguarding audit and health and safety. All of these highlighted if there was any issues or concerns noted and action to be taken to address them.

We also saw that fortnightly night visits were undertaken by the registered manager and deputy manager. These gave detailed information such as if the person had a call bell in reach, if they had a drink in reach, what staff were doing when the manager arrived, if night staff had completed all their jobs and if hourly checks had been undertaken. We saw issues had been identified on some visits, such as people did not have call bells or a drink in reach, one person was found with their legs hanging over their bed rails. We asked the managing director how and if improvements had been made in relation to some of the issues we had noted. We were informed that these were addressed immediately with the staff on duty and more recent night visits showed an improvement showing the importance of these nightly checks.

We were told the service did use agency staff when they had to but the agency staff they used were regular to the home. One of the registered nurses we spoke with said she had worked at the service for a year and liked working there but her family commitments meant she preferred to work for the agency.

There were policies and procedures for staff to follow good practice We looked at a number of policies and procedures within the service including, safeguarding, recruitment, infection control, confidentiality, development appraisals, supervisions, training and health and safety. These were accessible for staff and provided them with guidance to undertake their role and duties.

We saw a number of thank you cards that the service had received. Comments we saw included, "I want to thank all the staff at Hilltop Court for your love and support to my gramps and also to myself, your all just an amazing bunch and you don't get enough credit [name of two staff members] just to name a few and anyone else I missed. The work you do and the love you have for your residents and their families is just heart-warming so thank you" and "Thank you to all the staff for getting [name of service user] ready for his trips out."

The registered manager told us they sent out questionnaires to relatives as a means of gaining feedback about the service. These had been sent out in recent time and the service was awaiting their return at the time of our inspection.

The service held meetings with relatives regularly. On the first day of the inspection we were invited to attend a meeting and saw that people were able to bring their ideas and minor 'niggles' to put to the registered manager. The meeting was friendly and relaxed with people obviously able to say what they wanted to. This helped family members bring up topics which would help staff care better for people living at the home. Items we heard discussed included meals, the laundry, continuing care when people were transferred to hospital and general discussions around improvements that could be made. The registered manager made notes of the meeting and answered people's questions although she could not give firm dates for environmental improvements such as more leisure space for the men. During the meeting family members told us, "It is a fantastic home and the staff are second to none. The meals are fine although some staff do not appear to know he is on a soft diet but can have other foods", "The care is fantastic" and "Care staff do not shout at people here. Staff try to get people involved and entertained." Discussion with families was important because most of the people who used the service had advanced dementia and could not speak up for themselves.

We saw the records from another meeting. Items on the agenda included activities, decoration of the home, tagging of laundry, lost property, music, karaoke, staffing and care. Relatives were also offered to attend end of life care training to help them cope with the degenerating conditions of dementia.

Each member of staff were issued with a handbook when they commenced work and had to sign to say they had read it. The handbook contained details around good work issues such as key policies and procedures, the disciplinary and grievance procedures, data protection, recruitment requirements, a job description, training, confidentiality, the probation period, uniform and dress code, smoking, use of personal phones, the codes of conduct and gave some examples of what constituted misconduct. This document gave staff information around good practice.

People were given documentation called a Service User Guide when they were admitted to the home and a copy was available on the entrance notice board. This gave people a welcome to the home statement and informed them of the philosophy of care. It told people the facilities and services the care home could offer such as help with finances, meals and mealtimes, hobbies and activities and attending to their religious needs. There was a copy of the last inspection report and some of the rules of the home, for example where people could smoke. It also told people what was covered by the fees and what was not and contained a copy of the complaints procedure for people to raise any concerns. People were given sufficient information to know what the home provided.

There was also a statement of purpose available for professionals and families if they wished to read it. This provided the names, experience and roles of senior staff, the organisational structure, admission criteria, the numbers and experience of staff, leisure activities, care planning and reviews, quality assurance systems and maintaining contact with family and friends. It also informed people of the aims and objectives of the home. We noted this had been reviewed in April 2016 and alterations made to reflect any staffing changes.

We asked the registered manager what improvements they had made to the service since they commenced their role. We were given a file that the registered manager had put together as evidence of things they had implemented to improve the service.

We saw a reflection and prevention discussion took place around a safeguarding incident. This discussed the actions to be taken and lesson learned. All the staff had signed that they had attended and that they understood the discussions and had a chance to discuss any points themselves. This was good practice and showed the service was responsive to incidents and learning from them.

A newsletter had also been developed entitled the 'Hilltop Herald'. This was distributed monthly and included a message from the registered manager, upcoming birthdays, 'a relatives view', forthcoming events, what happened the previous month, bad joke corner, the months events in history, photographs and poems. The registered manager told us this was well accepted by people who used the service and their relatives. Relatives were encouraged to provide articles and help produce it.

Other improvements included the 'Hilltop Social Club' with karaoke, a bar, hot dogs, nibbles and a raffle. Fundraising was underway to raise money to install a sensory garden with highly scented flowers and bright colours. Enough money had been raised to purchase a garden shed which would be used as a rummage shed for those people who enjoyed gardening. The service was planning on having an opening ceremony for the shed by a gentleman whose wife had used the service. The managing director also showed us 'because I care charts' they had recently purchased. These were daily prompt posters with a set of messages to reinforce to care staff members to reinforce learning. For example one card stated "Does it have to happen now? If an individual doesn't want to get dressed or go to bed does it really matter? Even if it is something they need to do at some point, might it be less stressful for you both if you try again later?" The managing director told us they would be using these posters in staff meetings, daily stand-up sessions and theme of the day to reinforce the messages to staff. This showed the service was keen to promote quality care for people who used the service.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care and treatment of people who used the service did not always reflect their preferences and care plans were not always available to all staff.

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	Medicines were not always managed safely or stored securely.