Hilton House (Essex) Limited

Hilton House

Inspection report

175 Shrub End Road
Colchester
Essex
CO3 4RG

Tel: 01206763361
Website: www.hiltonhouse.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hilton House is a residential home registered for up to 10 people of all ages who have learning disabilities and mental health needs.

There were eight people living in the service when we inspected on 31 January 2016. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were needed in how the staffing levels were assessed in the service to ensure people's needs were met. Improvements were needed in the staff rota to show the actual times that staff worked. Appropriate recruitment checks were made to make sure that staff were of good character and able to work in the service. Staff were trained and supported to meet the needs of the people who used the service.

Improvements were needed in the service's safe management of medicines to ensure that people were protected.

Improvements were needed in the application of the Deprivation of Liberty Safeguards (DoLS). People were provided with a choice of meals, improvements were needed in how staff were guided to meet people's specific dietary requirements. People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

Staff had good relationships with people who used the service and were attentive to their needs. People, or their representatives, were involved in making decisions about their care and support.

Improvements were needed in how people's care was planned and how staff were provided guidance on how people's needs were met in care plans.

A complaints procedure was in place, however this was not displayed in the service and was not provided in an accessible format to support people to raise concerns. People's views about the service were sought in meetings and satisfaction questionnaires.

The service did not have a robust quality assurance system to independently identify shortfalls and to continually improve. This includes shortfalls identified in the environment, records and governance.

Prior to our inspection visit we received information of concern from other professionals. When their investigations are complete we will make a decision on our regulatory action. If we do take further action we

will report on this.

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

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 consistently safe.

Improvements were needed in the way that the staffing levels were assessed and recorded. Recruitment of staff was completed to make sure that staff were able to support the people who lived in the service.

Improvements were needed in the service's management of medicines.

Improvements were needed in the service's systems for ensuring people's safety.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained to meet the needs of the people who used the service.

The Deprivation of Liberty Safeguards (DoLS) were not sufficiently implemented. Referrals had not been made where required.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. Improvements were needed in how staff were guided on how people's specific dietary needs were met.

People had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

People and their relatives were involved in making decisions about their care and these were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed in how staff were guided to provide personalised care and support to people.

There was a complaints procedure in place but this needed to be accessible to people who used the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were asked for their views about the service and their comments were listened to and acted upon.

The service did not have a robust quality assurance system in place to independently identify shortfalls and to ensure that the service was continually improving.

Hilton House

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 inspection took place on 31 January 2016, was unannounced and undertaken by two inspectors.

Before our 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 looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority.

We spoke with six people who used the service and one person's relative. We also observed the care and support provided to people and the interaction between staff and people.

We looked at records in relation to three people's care. We spoke with the registered manager, the deputy manager and two members of care staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Risks to people injuring themselves or others were limited because equipment, including a hoist had been serviced to check that it was safe to use and fit for purpose. However, we were not assured that the environment was suitable to ensure people's safety as their mobility needs changed. For example, one person used a walking frame to mobilise and their bedroom was on the first floor. There was no safe access to the first floor other than the stairs. We asked this person how they got up and down the stairs and they said, "I use the bannister, I know I shouldn't but sometimes I go on my hands and knees." Furthermore this person told us that they were due to attend hospital for an operation which would affect their mobility. We spoke with the registered manager about this and they said that this person could have a ground floor bedroom. A staff member also told us that another person was sleeping in a ground floor bedroom but their bedroom was on the first floor. The staff member told us this was because the person was at risk of falling when using the stairs. People using the service had lived there for many years and as they got older their needs were changing. The service needed to ensure that they could meet people's changing needs associated with their ageing.

People were not protected by the safe management of medicines. We found two pots of medicines with labels with two people's names on them on a tray on a work surface in the kitchen. Prior to our entry the kitchen had been unlocked and unattended. When a member of staff entered the kitchen they told us they were about to administer these medicines to people which had been dispensed into the pots the night before and left for them to give. The registered manager then entered the kitchen and said they had just dispensed the medicines and were about to take them to the people who should be receiving them. Either version does not represent safe practice as the medicines had been left unattended and could have been taken by somebody entering the kitchen. This was also contrary to the service's medicines policy which stated, 'Medicines must only be removed from the original containers at the time of administration, medicines are given to the service user directly from their own labelled medicine container or the medicine is placed into a medicine pot before handing to the service user.'

When we looked in the refrigerator in the kitchen where food was stored we found a bottle of medicine on a shelf in the door. There was no date of opening on the medicine. This was unsafe because people could access this easily. The registered manager said that this medicine was due to be returned to the pharmacy and said that people would know not to use it. This was contrary to the service's medicines policy which stated, 'medicines that require cold storage are stored in a designated locked container in the refrigerator.' Therefore the service was not following their own policy. In addition to this there was a bottle of olive oil ear drops on a shelf in the kitchen.

Where people were prescribed with medicines that were to be administered when required (PRN), such as medicines for use to manage anxiety, there were protocols in place to guide staff when these medicines should be given. These did not offer sufficient detail to staff on the types of behaviour that people may exhibit, for example, "Agitation," which can be different for every person. Administration records did not identify the reasons for administration, nor did the incident and behaviour records. These did not sufficiently detail the types of behaviours that people displayed to warrant the use of the medicine, what other action

had been taken to support the person and any triggers to the person's distress. Therefore we could not be assured that the systems in place for administration and management of medicines were robust enough to ensure people's safety.

This is a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were safe living in the service. One person said, "I am safe here." One person's relative said that they felt that their relative was safe living in the service and how they were escorted by staff in the community to ensure their safety.

Records showed that staff had received training in safeguarding adults from abuse. However, one staff member spoken with did not have an understanding of safeguarding and how to report concerns to ensure people were safe. They could not tell us about the types of abuse saying that people should receive their personal care correctly. We were advised that the local authority and police had investigated a safeguarding allegation in February 2015. The service had not notified us of this, therefore we were not assured that the service reports concerns of abuse to the appropriate bodies, regardless of the outcomes of investigations.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risk associated with mobility and using services in the community. These risk assessments were regularly reviewed and updated.

People told us that there were enough staff available to meet their needs. One person said, "They [staff] help me." We saw that staff were attentive to people's needs and requests for assistance were responded to promptly.

The registered manager told us about how the service was staffed each day, having three staff on day shifts and during the night there was a staff member who was awake and another who slept in. The registered manager told us that they were also on call and could attend the service quickly if needed. The staff rota did not include the actual times that staff worked to reflect what we had been told. The registered manager and deputy manager told us that the working times were flexible but they always ensured there were sufficient staffing numbers. The rota also did not include the full names of staff on duty, this meant that in case of an incident it would be difficult to identify who was actually on shift. The deputy manager told us that they did not use a dependency tool to assess the numbers of staff needed in line with people's needs. They said that an inspector from the previous regulator had recommended that three staff be on shift during the day. The registered manager said that because the service was small they could manage this safely. Without robust assessments the service cannot be assured that there were sufficient staff numbers on duty at all times to meet people's needs.

When we arrived at the service a staff member told us that they had slept in the night before and another staff member who had been awake during the night finished work at 9am but was leaving at 10am due to the public transport on a Sunday. They said that the registered manager was due in on shift at 10am. We had arrived at 9:30am the registered manager and deputy manager were not on duty. This meant that the staffing levels of three staff during the day were not in place before they arrived.

We spoke with the registered manager about a staff member who worked in the service who the registered manager had told the police did not speak English. The registered manager said that they were assisting this staff member with their English but they could understand what was being said to them, they spoke in, "Broken English," and could communicate with people who used the service. They always worked with

another staff member. When we looked at the rota, it showed that this staff member was on the night shift with the first staff member we spoke with who told us that they had slept in. When we asked the registered manager about this, they told us that the staff member we had met was on waking night duty and the other staff member had slept in. We could not be sure what these staffing arrangements were because the rota was not clear and the conflicting accounts given by one staff member and the registered manager. We were not assured that the appropriate arrangements for safe staffing were in place, this was because if an emergency occurred one of the staff members either waking or sleeping in did not have a good enough understanding of the English language to communicate effectively with people who used the service and others.

One staff member told us that the night waking staff had breaks when they wanted them throughout the night. The registered manager said that the night waking staff had their breaks before the registered manager went off duty. There were no records in place to show how staff managed their breaks during the night.

Records showed that checks were made on new staff before they were allowed to work alone in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

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 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. Staff had been trained in MCA and DoLS. The registered manager told us that there had been no applications made under DoLS to the relevant supervisory body, this was because people were not deprived of their liberty. However, our observations and records seen did not assure us that this was the case. For example, people's care records did not identify people's capacity to make their own decisions sufficiently and were contradictory in parts. There were MCA1 forms in place but these were not sufficiently incorporated into care plans to identify the support people needed. Two people's care plans stated that the staff were to hold their hands when crossing the road, "Hands held for this activity," there was no other information to show if people did not choose to do this. Another person's records stated that they were to be escorted in the community by staff and that they were to walk arm in arm with the person, "Must be supported one to one when accessing anywhere out of the care home," and, "Requires one to one arm in arm support". Again this was not sufficiently explored in the records if this was the person's choice or used as a form of restraint.

Some cupboards where food was stored in the kitchen were locked. The registered manager told us that one was locked because it was a stock of food and other food to be used was in unlocked cupboards. The cupboard they showed us to corroborate this only held spices and seasoning. People's records did not contain details of why the food was locked away, and if this had been done to safeguard individuals and how it affected the other people living in the home. Three bedrooms, one which was shared, had padlocks on the wardrobe doors. In the shared bedroom, these padlocks were not locked. A staff member told us that they were in place because the people who stayed in these bedrooms often took all of their clothing out. In another bedroom all the padlocks were locked and there was an office type cabinet which was locked. A staff member told us that this cabinet held the person's, "Good clothes," and it was locked because the person liked to take their clothing out. In another person's bedroom which held locked wardrobes, the person told us, "I used to take my clothes out and wet them all. I want them locked." The registered manager told us that people had chosen to have their wardrobes locked and that they all had keys. There was no detailed account of this in people's care records and due to the different accounts it was not clear for the reasons for this. Therefore we were not assured that the service was working in accordance with DoLS.

This is a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People's records showed that people's dietary needs were assessed. Where issues had been identified, such as the risk of choking, guidance and support had been sought from health professionals, including a speech and language therapist (SALT). However, one person's records were contradictory and difficult to follow relating to the food that they could safely eat. They had been assessed at risk of choking and guidance from the SALT stated that they should be provided with food at a pudding consistency to minimise the risks. However, in another part of the person's records their favourite food was listed as fish and chips and biscuits, in another part guidance stated that the person's food was to be cut up into bite sized pieces. Therefore, the records did not provide easy to follow guidance to staff on how this person would be supported to eat safely.

This is a breach of Regulation 9: Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to ensure that staff received training and were regularly supervised. The registered manager told us that they used a training provider and they felt that the quality of training was good and that the staff had the knowledge to meet people's needs effectively.

Training was arranged on a yearly basis (at the beginning of each financial year). Certificates for each staff member were held on their personnel file. The registered manager did not maintain a records of who had done what training and when. When asked they stated that this was dealt with at supervisions and they were aware of what training staff had undertaken.

New staff undertook a formal induction which was completed in the first week of employment. This included an introduction to their role and responsibilities, communication strategy and service policies and procedures. The registered manager told us that the new member of staff then worked as supernumerary to existing staff for a 12 week period. This was confirmed by one staff member who told us that they, "Followed," other staff when they started working in the service. We asked the registered manager about their plans for providing staff with the opportunity to complete the new care certificate. There was no plan in place and the registered manager did not have a clear understanding of what this was. This meant that they had not kept up to date with changes in guidance for staff induction.

Staff received monthly supervisions where their performance was discussed along with any areas for development. The registered manager said this was how they monitored training and any areas for development. However, staff yearly appraisal records did not demonstrate how they were used to develop staff and drive improvement. For example one question on the appraisal record asked "Thinking about the way you are managed what would you like your manager to, stop, start, continue?" The word continue had been circled but no explanation of what was to stop, start or continue had been given in the space provided. Also another question asked, "What are your career aspirations, short, medium, long term?" The words long term had been circled but again no explanation had been given in the space provided what the staff member's long term aspirations were and how the service would support them with their ongoing professional learning and development.

People told us that the staff sought their consent and the staff acted in accordance with their wishes. This was confirmed in our observations. We saw that staff sought people's consent before they provided any support or care, such as where they wanted to be in the service and if they required assistance.

People told us that they were provided with choices of food and drink and that they enjoyed the food in the

service. One person said about their meal, "That was a nice roast." Another person told us that they had chosen what they wanted for breakfast and showed us their porridge and said, "Nice."

We saw that people were provided with the food of their choice and there was a display of pictures of food in the dining room which showed how people made their choices about the menu for the day.

One person told us how the staff had helped them to maintain good health which included losing weight and stopping smoking, "I am better now." They showed us a photograph of before they lost weight and said, "Look I am better."

People's health needs were met and where they required the support of healthcare professionals, this was provided. One person told us that they were due to have an operation and that the staff had been with them to previous appointments. One person's relative said that the staff had supported their relative to attend appointments to investigate an issue with their health.

Records showed that people were supported to have access to healthcare services and receive ongoing healthcare support.

Good

Is the service caring?

Our findings

People told us that they liked the staff who worked in the service and that they treated them with kindness. One person said, "They [staff] are nice to me."

Staff talked about people in a caring and respectful way. We saw that the staff treated people in a caring and respectful manner. People were clearly comfortable with the staff, they responded to staff interaction by smiling, laughing and chatting to them.

People told us that they felt staff listened to what they said and their views were taken into account when their care was planned and reviewed. One person said, "Yes staff listen to me." One person's relative told us that they were consulted about the care and support provided to their relative and that they had read their care plans and agreed with the contents. People's bedrooms were personalised with person's own possessions. The deputy manager said they had recently re-decorated several bedrooms to people's choice and if they wanted them to be done again differently this would be done.

Records showed that people and their relatives, where appropriate, had been involved in planning their care and support. This included their likes and dislikes, preferences about how they wanted to be supported and cared for. Where people were able they wrote in their own care plans about how they wanted to be cared for.

People told us that they felt that their choices, independence, privacy and dignity were promoted and respected. We saw that staff respected people's privacy and dignity. For example, staff knocked on bedroom doors before entering.

Requires Improvement

Is the service responsive?

Our findings

Care plans were written in a person centred way and, where able, people had contributed to their care plan by writing their own wishes. However, people's care records were contradictory in parts and therefore guidance for staff in how people's needs were met was confusing. For example, one person's care records stated in one part, "I do suffer from irregular sleeping pattern," and in another part stated, "I have a good sleeping pattern. I like to go to bed early and have more than eight hours sleep."

Records to monitor people's behaviours did not identify the type of behaviour displayed, circumstances leading up incidents to allow effective monitoring to identify what may trigger the behaviour and allow strategies to be put in place to reduce the behaviour. For example one person's record used single words such as shouting, restless or anxiety. A risk assessment template in people's records used terms such as, "Attention seeking," which does not reflect current best practice. Guidance provided to staff in how to support people with their behaviours were recorded in a way which could be seen as punitive. Statements included, "Apology must be inferred and reward should be given after an apology is provided," "Unsociable profane language is not respected and treated with firmness and control preferably by male staff," "If in public return home immediately. If at home return to personal room," and, "No rewards are to be given if demonstrated [type of behaviour] and staff to support to return home safely to reduce level of risk and offence to members of the public."

Person centred progress reports were in place which identified any changes in people's wellbeing and needs on a monthly basis. However, some of these were not dated so a clear picture of a person's wellbeing over time could not be monitored.

This is a breach of Regulation 9: Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received personalised care and that their views were listened to and acted on. One person said, "I love it here, I love this house." They told us about the different service they had lived in, "This is the best."

People told us that there were social events that they could participate in, both individual and group activities. One person said, "I am going to church with [another person]." They said that they enjoyed this and went every Sunday. This was confirmed by another person and our observations, these people did attend church with a staff member. Another person told us about how they liked to go to college and the different activities they participated in at the service and in the community, including a pop concert, which they showed us photographs when they went to see a band.

During our inspection we saw people participating in activities. This included knitting and board games.

There were individual activity plans on a wall in the service for each person. They were in text format which was not accessible to the people who used the service. A staff member told us that they reminded people

what was on their plan but they always chose what they wanted to do and the plan could be changed to meet with their preferences.

People could have visitors when they wanted them and one person's relative confirmed that they could visit at any time. This meant that people were supported to maintain relationships with the people who were important to them and to minimise isolation.

Regular meetings were held with people to discuss any matters of concern. For example at a recent meeting the recent death of a person living at the service had been discussed. People filled in their opinion of the meeting at the end of each meeting, one person had recorded, "I like to mention my thoughts."

The service had a complaints policy. However, this was not displayed in the service and was not available in an easy read format to enable people to understand it and make a formal complaint if they wanted. It also advised people that they could ask for a review by the Care Quality Commission which was not correct.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have robust quality assurance systems to identify shortfalls and to drive continuous improvement. In the service's PIR for each domain where they were asked about planned improvements for the next 12 months they had stated, "At present we are achieving our highest standard of care and aim to continue excellent practice for the [domains: safe, effective, caring, responsive and well-led] of our residents and we welcome improvements and recommendations." Audits and checks were not made in areas such as medicines, falls and records. Incidents were not analysed to identify possible trends to allow the service to make improvements to minimise the risks happening again. The provider was also the registered manager and told us that they worked in the service daily and this was how they kept the service under review and monitored the values and behaviours of staff.

In the shared bedroom we saw that the glass on a framed picture on the wall was cracked, which was a risk to people cutting their fingers on it. There was a brown stain on one of the arm chairs. The en-suite toilet needed flushing and when we pointed this out to a staff member the flush did not work. They said it had the night before, the registered manager told us that they had called a plumber and this would be addressed.

Food stored in the refrigerator such as margarine, grated cheese in a margarine tub, salad cream and jam did not have labels on them to show when they had been opened. There was also an uncovered jug of milk with no label when this had been poured from the bottle. There was an out of date beef burger in the refrigerator which the registered manager told us that all food on the top shelf belonged to staff. On another shelf there was a bag of defrosting vegetables, the registered manager said that this also belonged to staff. There was a carrier bag with food in it, when we asked the registered manager what these were and how long they had been stored, they threw them in the bin and said that someone from the church had brought them in. In the freezer there were several bags of frozen vegetables none of these were labelled showing what they were and when they were frozen. When asked for audits relating to, for example, infection control and maintenance, the registered manager replied, "We don't have audits because the home is small. We rely on people's training." There were no systems in place to monitor the safety in the service and the safe storage of food.

We saw a report from the council which stated that an extended part of the service was in breach of building regulations. Despite telling us this had been addressed the registered manager could not provide us with documentation to evidence this.

The registered manager and deputy manager were not clear on all incidents that they were required to notify us of. This included all issues relating to safeguarding and pressure ulcers.

This is a breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave positive comments about the registered manager. One person said, "I love [registered manager]." Another person commented, "[Registered manager] looks after me, I like her."

People were involved in developing the service and were provided with the opportunity to share their views. Satisfaction questionnaires were provided to people on an annual basis. The registered manager said that they had 100% satisfaction from people, which was confirmed in records. They said that if they did have concerns in these questionnaires action would be taken to address them.

The registered manager and the deputy manager told us that they kept updated with changes in the care industry by regular updates from CQC. They were aware of our enforcement policy. They also told us that they attended network meetings run by the local authority which kept them up to date with any changes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care records did not guide staff sufficiently on how service user's needs were planned for and met. Regulation 9 (1) (a) (b) (3) (b) (c) (d) (e) (f) (g) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in accordance with the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Risks associated with the environment were not appropriately assessed to ensure service user's changing needs were met safely. Regulation 12 (1) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have robust systems in place to monitor and assess the service provided to service users. Regulation 17 (1) (2) (a) (b) (f).