Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Hillcrest Dorset

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Tel: 01202578136

Date of Inspections: 22 August 2013
21 August 2013
20 August 2013

Date of Publication: October 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Hillcrest Care Limited
Registered Manager	Ms. Alison Bartlett
Overview of the service	Hillcrest Dorset provides care, including personal care, and support to adults with learning disabilities in their own homes. Many of these individuals require support over a 24 hour period.
Type of services	Domiciliary care service Supported living service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 20 August 2013, 21 August 2013 and 22 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

This was Hillcrest Dorset's first inspection at its current location. We last inspected the service in February 2013 at its previous address.

During our inspection we met four people who used the service, and spoke with two of them, with two relatives and with a community learning disability professional. Not everyone was able to tell us about their experiences so we observed how staff worked with them, examined records and spoke with the manager and six staff involved in providing care.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We saw that staff respected people's choices.

People experienced care, treatment and support that met their needs and protected their rights. Everyone we spoke with told us they felt people were safe with their support workers.

People were protected from the risk of infection because appropriate guidance had been followed.

There were enough qualified, skilled and experienced staff to meet people's needs. People and staff confirmed there had recently been less reliance on agency staff. We noted that support workers had been recruited recently.

The provider assessed and monitored the quality of the service, and assessed and managed risks to people's health, safety and welfare.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We pathway-tracked four people. This meant we visited them, talked with them where possible about their care, looked at their care records, and spoke with support workers who assisted them. Where appropriate we observed support workers as they assisted people. This was so we could evaluate how the people's care and support needs were assessed, planned and delivered. None of the individuals discussed their care in depth.

We observed that staff treated people with dignity, respecting their wishes. For example, we observed a senior support worker telephone one individual we were pathway-tracking. They asked the person if they were happy for them to bring a colleague when they visited later that day, before confirming the appointment with the colleague. We saw during all four visits that support workers checked that people wanted assistance before providing this and that they explained to individuals what they were going to do. With one individual who was not able to verbalise their wishes, we saw that staff suggested things they might like to do and were responsive to signs that the person wanted to do something else.

People's support plans promoted choice and decision making. The support plans for all the individuals we pathway-tracked contained guidelines for staff on how to support people to make choices themselves. For example, one person's support plan explained that they communicated non-verbally and set out signs they showed when they wanted particular things. Another individual's support plan listed their food preferences and instructed staff, "Ask me what I would like to eat. Discuss my diet over the last few days as I can usually remember what I have had and then we can work out together what would be healthiest for me to have". Their food diary, which reflected their food preferences, showed that staff had followed this instruction.

This showed that before people received any care or treatment they were asked for their consent, where they had capacity to give this, and the provider acted in accordance with

their wishes.

Where people did not have the capacity to consent in particular situations, the provider acted in accordance with legal requirements. For example, three individuals' care records contained evidence of best interest decisions in line with the Mental Capacity Act 2005, for staff to support them with their medicines. The provider had reached these decisions in consultation with the individuals' circles of support, including their family and community learning disability team staff.

People's support plans included information that assisted staff to respect people's wishes and best interests, in the event they were unable to make or communicate a decision themselves. For example, the support plans for the four people we pathway-tracked contained details of their preferences in various aspects of their daily lives, such as eating, personal hygiene and grooming, and routines.

The provider's training records showed that 75% of staff had received up to date training about the Mental Capacity Act 2005. Copies of course certificates on the four staff files we looked at showed the staff members had all received this training within the past year. We noted that this was included within the induction for newly recruited staff and that it was refreshed periodically following this. The manager demonstrated a clear understanding of the principles of the Mental Capacity Act and when best interest decisions were required.

We saw the provider had a Mental Capacity Act policy that had been reviewed earlier in 2013. This set out the key principles of the Mental Capacity Act 2005 and gave staff guidance about when and how to assess mental capacity in relation to particular decisions. It also explained how staff should make best interests decisions, if individuals were assessed as not having the capacity to make those decisions themselves.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We met the four people we pathway-tracked, and spoke with the two who were able to talk with us. The individuals indicated they liked and felt safe with their support workers. They said that staff supported them to do things they enjoyed inside and outside their homes. One person showed us the biscuits they had made earlier that day. We observed people were relaxed with their support workers and readily communicated with them.

We also spoke with two relatives who were broadly positive about the support their family member received. For example, one said, "In general terms, [person] is well looked after". The other said they felt that Hillcrest Dorset were doing what they could to support their relative in view of external funding limitations.

All four people we pathway-tracked had support plans based on their assessed needs and risks to their health and welfare. These took account of people's preferences and addressed the support they needed with various aspects of their daily lives, such as eating and drinking, physical and mental health and communicating.

The support plans for the individuals we pathway-tracked were person-centred and contained extensive instructions for staff to assist them in the way they needed. We observed that support workers followed these instructions. For example, we watched a staff member supporting one person to make tea. They encouraged the individual to do as much as they could for themselves, giving them simple directions when needed. This was consistent with the person's support plan.

The support workers we spoke with confirmed they found the support plans useful. They demonstrated comprehensive knowledge about the people we were pathway-tracking and the support they required. For example, after consulting with one individual the support worker with them showed us their special word book and explained to us how they used this. This helped ensure people received support that met their needs.

Where we were unable to observe care being provided we looked at relevant records that showed staff had taken the necessary actions to meet people's needs. For example, we checked the most recent medication administration records for the people we were pathway-tracking. These were completed correctly, showing the individuals had received

their prescribed medicines. One person with a bowel condition needed support workers to monitor their bowel movements and offer additional laxative medication after a specified interval. Records reflected that staff had followed this plan.

We also observed that people were clean and neatly dressed. This showed that people had been supported to maintain their personal hygiene.

We noted that people's support plans were up to date, reflecting their current needs. We saw these had been reviewed and updated at least annually.

This all showed that people's needs were assessed and care and treatment was planned and delivered in line with their plans of care.

Care was also planned and delivered in a way that was intended to ensure people's safety and welfare.

All the people we pathway-tracked required support to maintain their health. Their support plans addressed their physical and emotional health and wellbeing. For example, we saw that one person had a support plan regarding their self-harm. This assisted staff to distinguish between the individual's signs of pain and of distress. It promoted the person's dignity and choice by requesting, "Please be very discreet about any injuries from self-harm" and stating that staff should seek their permission before contacting their doctor. There were clear guidelines for staff to respond safely whilst not overemphasising incidents and reinforcing the behaviour.

The manager explained that this individual had a history of aggression to others when they were distressed. We saw this was reflected in the person's current risk assessment for behaviour that challenges. The person had a behaviour support plan based on the risk assessment. This had been devised earlier in the year in consultation with the person's community learning disability team. It gave clear strategies for staff to manage the person's behaviours in particular situations, in order to keep the person and other people safe. We observed certain aspects of the plan in operation, such as the person having access to a one-cup kettle under supervision at times when they were not distressed.

People's care records showed that staff supported them to attend annual health checks and other appointments with healthcare professionals such as general practitioners, hospital specialists, dentists and community learning disability staff. The manager explained that one of the people we pathway-tracked, who had previously resisted dental consultations, had started to attend dental appointments at the dentist's surgery in the past year. Their records confirmed this. This all demonstrated that the provider ensured people's healthcare needs were met.

There were arrangements to deal with foreseeable emergencies. For example, the four staff files we looked at showed that staff had undertaken first aid training within the past year. The provider's training matrix showed that first aid training was planned for those who were due an update. Records also showed that staff received training in managing aggression. We also saw that people we pathway-tracked had personal emergency evacuation plans for use in the event of a fire or similar emergency at home.

We saw the provider maintained an on-call file for the senior support workers and managers on-call outside office hours. This contained a profile and summary for each person using the provider's services so that staff had access to key information about them, including their support plan. The file also contained local safeguarding information

and on-call procedures.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection.

We observed that people and their home environments were visibly clean. This indicated they had received the support they needed to maintain their personal hygiene and the cleanliness of their surroundings. We saw records showing this was monitored each week by the senior support worker for the person's service.

We saw boxes of vinyl gloves in the homes of the people we pathway-tracked. Their support workers confirmed they always had enough personal protective equipment, such as disposable gloves and aprons, provided by Hillcrest Dorset. One commented that there were boxes of gloves in every room in every flat in one small block where several individuals lived. The senior support workers' weekly monitoring forms showed they checked the adequacy of personal protective equipment supplies.

The support workers we spoke with told us they had received training in infection prevention and control, including handwashing techniques and use of personal protective equipment. They were able to explain the procedures Hillside required them to follow for dealing with soiled laundry and with waste containing body fluids. All four staff files we checked contained copies of certificates for attendance at infection prevention and control training within the past year, and during their induction as new employees. The provider's training records showed that over 80% of staff had received up-to-date induction or refresher training in infection prevention and control.

Staff files and training records also showed that over 80% of staff had received up-to-date induction or refresher training in food hygiene. The manager told us staff were not allowed to work for 48 hours after recovering from vomiting or diarrhoea. Staff we spoke with confirmed this.

We asked to see job descriptions for staff who provided care. The provider may find it useful to note that these did not specifically refer to infection prevention and control. The guidance for compliance with criterion 6 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance states: "Infection prevention and control would need to be included in the job descriptions".

The manager informed us that Hillcrest Dorset did not have a named individual lead for infection prevention and control. However, they told us a senior support worker was considering taking on this role. They also told us that a senior staff member addressed infection prevention and control within their health and safety lead role, including attending quarterly health and safety meetings with the health and safety lead at the parent company. We noted the provider had an infection control policy that had been reviewed in July 2013.

The manager explained that the parent company's human resources department dealt with occupational health matters, including issues arising from staff health screening questionnaires during recruitment. They explained they encouraged all staff who had not already done so to receive Hepatitis B immunisation, and also annual influenza immunisations, at the provider's expense. We saw the standard letters they completed for staff to give to their general practitioners, explaining their role and their need for immunisation. The staff files we read showed that staff had signed to say they had read the information provided about Hepatitis B, understood the provider's recommendation and understood the risks of not being immunised. This showed that Hillcrest Dorset ensured that staff were protected against infections that could be caught at work.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

We observed that the four individuals we visited were relaxed with their support workers and readily engaged with them. We also noted that their support workers were familiar with their preferences and needs.

Support workers told us they received sufficient training to enable them to perform their roles. One commented, "The training's really good". Training records showed that new staff received comprehensive induction training, which was refreshed periodically for all staff. This training covered topics including handling medicines, safeguarding vulnerable adults and health and safety. The four staff files we looked at showed that staff had supervision meetings with their line manager at least every two months.

This all indicated that staff had the skills to meet people's needs.

Two people's relatives told us their family members had experienced changes in their staff teams during past months. They said that these changes had been difficult for the individuals, for example, making it harder for them to access activities they enjoyed. One commented that at one stage their relative had been supported by agency staff who they did not know.

The manager informed us that Hillcrest Dorset had recently recruited support workers and this meant they were reducing their use of agency staff. They said they were now fully staffed and explained that people had dedicated teams of support workers providing care. The July and August staff rotas showed consistent teams of staff, without agency staff, supporting the people we pathway-tracked for 24 hours a day, including sleep-in duties. This meant that people could get to know their support workers and experience consistency of care.

All the support workers we spoke with, except for two new members of staff, told us that there were sufficient staff for them to support people properly since the additional staff had been recruited. The rotas we saw allowed staff handover time and we observed support workers handing over between shifts during one of our visits.

Staff told us they received their duty rotas several weeks in advance. One support worker said that the person responsible for organising the rotas was "really spot on" with this. The rotas we saw showed that support workers had adequate rest days each week.

The manager confirmed that staffing levels depended on funding agreed with the authorities commissioning individuals' services. For example, some of the people we pathway-tracked were funded to receive 2:1 support equivalent to a certain number of hours each week. The manager explained that they tried to arrange this additional staff support when people were best able to use it, for example to attend special events, rather than provide support when people's regular outside activities had stopped for the summer holidays. We saw that people's rotas reflected this.

We checked the on call log and found no concerns about support workers missing shifts.

This all showed there were enough staff to meet people's needs.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

Two people's relatives confirmed they could approach management with any immediate concerns about their family member's service. For example, one said, "I would feel quite comfortable doing that". They confirmed they had the necessary telephone contact details. They confirmed Hillcrest Dorset involved them in decisions about their family member's care, for example, by inviting them to reviews.

We asked to see details of complaints received since February 2013, when we inspected the service at its previous premises. The manager showed us records of three complaints. These had been acknowledged, investigated and resolved in line with the provider's complaints policy. We noted that the manager had recorded a thorough investigation of each, including interviews with the staff involved and reviews of documentation. They had taken action to address any issues identified. This showed that the provider took account of complaints and comments to improve the service.

The manager confirmed that Hillcrest Dorset carried out an annual stakeholder survey to obtain the views of people using the service, their relatives and staff. The manager explained that returns from the last survey in autumn 2012 had been limited due to the way the questionnaire was constructed, for example, its length, complexity and repetition. The questionnaire had been based on a widely recognised set of standards for learning disability services. We saw the analysis of the results and an example of an individual action plan for one person. We noted that individual action plans were to be provided to people's stakeholders for their review and comment with the next stakeholder survey, which was planned for September 2013. The manager told us they had spoken with stakeholders to check how they would prefer to receive the survey, for example by e-mail or over the phone.

Support workers told us the provider checked their performance through regular checks of their work, including spot checks. They also explained that they were expected to record and sign a handover checklist to show they had accounted for matters such as cash and medicines. For the four individuals we pathway-tracked, care records contained records of these checks at each staff handover. The provider's records contained evidence of other regular checks. These included senior support workers' weekly monitoring reports on many aspects of people's care such as health and safety issues, daily care records, and completion of handover records and medicines administration sheets. We also saw that people's paperwork was checked by senior staff when it was returned to the office each month. The manager made regular reports to the provider on quality issues, such as complaints, accidents and staff sickness. This showed the provider monitored the services people received to protect them against the risks of inappropriate or unsafe care.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. For example, care records for the people we pathway-tracked contained individualised risk assessments and management plans relating to their home environments and the activities they undertook.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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