Inspection Report

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

Hillcrest - Vernon

10 Maltravers Drive, Littlehampton, BN17 5EY

Tel: 01903716556

Date of Inspection: 30 January 2014

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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
Meeting nutritional needs	✓ Met this standard
Requirements relating to workers	✓ 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	Mr. Stephen Hindmarch
Overview of the service	Hillcrest Vernon is a residential care home proving accommodation, care and support for up to 14 people with learning disabilities. This includes people who may also have a physical disability, sensory impairment or a specific health need. At the time of our visit there were 13 people in residence.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or 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 unannounced 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 30 January 2014, 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 and talked with staff.

What people told us and what we found

We spoke with two people living at Hillcrest – Vernon during our visit. They were very satisfied with the service provided. One said, "The staff are very kind, they know what they're doing". The other told us, "I'm comfortable".

We spoke with six members of staff and the manager. Staff told us that it was a good place to work and that they felt people received good support. One said, "It's a really fun job". Another told us, "It's rewarding".

While we did not meet any relatives on the day of our visit, comments from relatives gathered as part of the home's satisfaction survey were overwhelmingly positive. These included, 'The general care of clients is outstanding' and, 'X has come alive and seems totally happy since they transferred to Hillcrest'.

We also gathered evidence of people's experiences of the service by observing how people were supported by staff and by looking at records. We found that people's care needs were being managed safely by the service and that staff had a good understanding of their roles and responsibilities.

We found that the support people received was individualised to their needs. People's rights with regard to consent were being promoted by the service and staff understood how people's capacity should be considered. People were supported to eat a varied diet which took account of their preferences. People told us that they could approach the staff and manager if they were unhappy or had ideas to discuss.

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

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We observed that staff involved people in decisions relating to their day to day care and support. For example we heard a member of staff asking, "Do you want to go to the lounge or down to your room". The person led the member of staff in the direction of their room. We also saw a member of staff respond to body language from a person who was unable to communicate verbally. This person appeared to have had enough to drink. To confirm, the staff member said, "Push it away if you don't want it", which the person did. One person told us, "They let me do what I want, they don't force".

Staff that we spoke with said that they took time to speak with people and to check that they were in agreement. One said, "If X doesn't want to get up you leave and come back" and, "X won't put shoes on if they don't want to go". We noted that care plans prompted staff to offer relevant choices. For example we read, 'I like to choose my own clothes each day in the morning so please offer me a number of items of clothing and I will either push them away to indicate that I do not want that one or pull it towards me to let you know this is the one I want to wear. This can often take some time but please spend this time with me'. Daily notes that we looked at demonstrated that where, at times, people refused choices or support this was respected.

We saw that each person's care plan included a section on their capacity to make decisions. For example we read, 'I am able to make simple choices on what I want and don't want and will show this by vocal noises'. Records that we looked at demonstrated that people had made decisions regarding their health needs. For example one person had requested that a particular member of staff supported them to attend a doctor's appointment for a screening procedure. Staff told us that they had used pictures to explain and discuss the procedure with the person. Another person was supported by an

independent advocate in order to understand and represent their views.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. The manager shared with us an example of a best interest meeting that had been called regarding a specific treatment needed by one person they were supporting. We also noted examples of when the home had contacted the Deprivation of Liberty Safeguards (DOLS) team to ensure that they were working in line with this legislation.

Staff had received training in the Mental Capacity Act 2005 which included the DoLS. Staff that we spoke with understood their obligations with respect to people's rights and choices when they appeared to lack the capacity to make a particular decision.

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.

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

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at four care plans. They were focused on the individual and were detailed. Where risks had been identified, we saw that assessments were in place. Each area of support included information on, 'What I can do for myself', 'What I need you to help me with' and 'How I want you to support me and in what order'. Where a person required specific support, such as for seizures, depression or suction to keep their chest clear, detailed guidelines were in place. Staff told us that they found the care plans helpful. One said, "Before you even meet them you know how to help them".

The care plans contained detailed information on how people communicated. For example we saw information on how people said 'yes and 'no' or choose between items. We read, 'I will also look to either side if given the option of two items'. Staff shared examples with us. They told us, "X will squint their eyes if they've got a headache" and, "X will do this (demonstrated action) which means they want to go out for a beer".

Records demonstrated that people were monitored regularly. We saw records of weight and bowel monitoring, as well as seizure monitoring for some. There was evidence that care plans were reviewed on a regular basis. Actions from reviews that had taken plan in January were already complete. For example a new moving and handling plan was in place for one person. One member of staff said, "The care plan is constantly evolving".

Staff demonstrated a good knowledge of people's needs and how to support them. During our visit we observed the staff on duty interacting with people in a positive and supportive way. We saw people being helped to go out and to complete household tasks. People were observed moving freely around the home. The atmosphere was relaxed and inclusive. In the survey one relative said, 'A well organised home with a happy atmosphere. All the staff are always polite, upbeat and cheerful creating a wonderful home environment for X'. One person told us, "I get very down and they take me out and I feel better". Staff that we spoke with told us that they had enough staff on duty to enable them to deliver good quality support. One said, "I love it here, we do so much with them".

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Records and discussions with people confirmed that they were supported with

their personal care and health needs as necessary. These included regular checks with opticians, dentists and chiropodists. We observed that where necessary people were wearing glasses to aid their vision. In the satisfaction survey conduction by the home, one relative had commented that the home had, 'Good liaison with the community health team'. Staff told us that they had clear instructions on the support each person required. One told us, "It's all written down, we know when to call the doctor".

Where appropriate we noted that some people had a behaviour support plan. This included information on triggers for certain behaviours, early warning signals and what action staff should take to diffuse or intervene. One member of staff said, "You can see certain things building. We've got triggers and ways of calming down". Where physical intervention (PI) might be required a specific support plan and risk assessment was in place. Staff had been trained in a recognised method of PI. One told us, "PI training is focused on prevention". We noted that relatives had commented on the home's management of behaviour in the satisfaction survey conducted by the home. We read, 'Just to say thank you for working with X on their behaviour and managing the responses used. As a result they seem much more relaxed and less anxious'.

There were arrangements in place to deal with foreseeable emergencies. The home had a contingency plan. This included action to take in the event of a staffing crisis, communications failure or loss of accommodation. Staff that we spoke with were aware of this plan. They told us that they discussed it in staff meetings, for example recently they had discussed purchasing extra grit to be prepared for the cold weather that was forecast. Training records confirmed that staff had been trained in first aid. Evacuation plans were in place for people living in the home. They also had hospital passports. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health if they are admitted to hospital.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People's food and drink met their religious or cultural needs. We spoke with people and staff working at the home and also looked at people's individual care records. Although the home did not have anyone who required a special diet due to their cultural or religious needs we saw that where people had preferences for the type of food they ate, the home adapted to meet this need. Where people required a special diet, for example gluten free, alternatives such as gluten-free bread were available.

People were provided with a choice of suitable and nutritious food and drink. We saw that the menu was displayed in the kitchen. Staff told us that they wrote the menu with the people living in the home. One said, "They've asked for liver to go back on the menu". We noted that there were varied dishes on the menu, which included some take away meals and lunches at a local pub. One member of staff told us, "We have at least three vegetables a day and a lot of fresh fruit; I make sure there is colour on the plate". During our visit we observed that people were given choices on what they wanted to eat and drink. One person told us, "I'm having curry for tea tonight". Later we saw that they were in the kitchen chatting with staff as the evening meal was prepared.

People were supported to be able to eat and drink sufficient amounts to meet their needs. The home had a record of people's likes and dislikes, as well as information on whether they had specific needs such as a soft diet or if they needed their food cut for them. This enabled staff to provide people with food they liked and, for those who could not tell them what they wanted, with food they were known to enjoy.

We observed part of the lunchtime in the home. We saw one member of staff completing a 'swallow diary'. This was on the instruction of the Speech and Language Therapist (SALT). The member of staff explained to us how they supported this person at mealtimes. This matched the information in the person's support plan regarding the texture of food and how the person should be positioned while eating. We saw that some people used aids to maintain their independence at mealtimes. One person had a plate guard for their meal and others used straws to make it easier for them to drink.

Staff were able to explain how they adapted meals to suit people's different needs. For example that evening people who required a soft diet would have their curry with mashed potato rather than rice. Another person's curry would be cooked without onion as this helped to ensure that it was pureed sufficiently finely to avoid them choking. We read in

one person's care plan, 'Ideally I would like to lose weight so need support to design a healthier diet'. A member of staff explained how they were working with this person.

We noted that the home kept detailed records of people's food intake. We saw monthly weight records and noted that the home had made referrals to the GP and/or dietician where there was cause for concern. As a result one person had fortified drinks to supplement their meals. At the time of our visit fluid monitoring was not in place. This was because no one living in the home had been assessed as at risk of not drinking enough.

The home had been awarded the top food hygiene rating from the Food Standards Agency in October 2013. Staff training records that we looked at showed that staff had attended food hygiene training.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

There were effective recruitment and selection processes in place. The processes were managed centrally by the provider. Candidates were interviewed by two members of the home's management team, using a standard set of questions. Recruitment records that we looked at included completed application forms and an interview record for each member of staff.

Appropriate checks were undertaken before staff began work. The pre-employment checks included two written references and a criminal records check. This was to ensure that the person did not have any convictions that would mean they were unsuited to working with, potentially, vulnerable people. We looked at two staff files. These confirmed that the appropriate checks had taken place before they started work. Staff that we spoke with confirmed that this had been their experience. One said, "It took about a month to get to a start date, they won't let anyone start here before all the checks are complete".

A new employee check list was used to ensure all the necessary steps for safe recruitment had been followed, in line with the provider's recruitment policy. We noted that photographic identification, proof of address, copies of certificates mentioned in the application and evidence of the person's right to work in the UK were checked. Copies were stored electronically.

When a new member of staff joined the team, they initially worked alongside experienced staff. One recently recruited member of staff told us, "I did shadow shifts for two weeks. I was an extra". This ensured that they had the necessary skills and knowledge to meet people's needs.

Staff who were no longer fit to work in health or social care were referred to the appropriate bodies. The manager shared an example of a member of staff who they had dismissed. As part of this process a referral was made to the barring service. This demonstrated that the provider understood their responsibilities and acted upon them in order to protect people from harm.

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 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

When we inspected this service in March 2013 we found that the provider did not have an effective system to seek feedback from people who use the service and others with an interest in the service. Following our inspection, the provider sent us a report on the actions they would take to achieve compliance. These actions included reintroducing annual satisfaction surveys and regular residents' meetings.

At this visit we found that action had been taken and that the service was now compliant.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We looked at the results from a satisfaction survey completed in March 2013. The home had received a good level of response from relatives, staff and external healthcare professionals who visited the home. People who use the service had also been involved where possible, with support from members of staff. The questionnaire was available in an easy to read format with happy and sad faces to indicate satisfaction or otherwise. On one survey we read a note from the member of staff which said, 'I asked the questions and X pointed to the relevant picture'.

The responses were positive and a summary analysis had been completed. Where suggestions had been made, we noted that action had been taken. For example, people and their relatives had asked for more activities outside of the home. The manager showed us on the rota where additional staff cover had been scheduled to facilitate activities such as horse riding, swimming and visits to a local club night. This demonstrated that the home responded to feedback and took action to implement improvements. As a result of this feedback, the home had also introduced interaction charts to monitor the activities in and out of the home that people were engaged in. We noted that the manager had recently written to relatives once again, inviting them to discuss any suggestions they felt could improve the service.

Since our last visit, the home had also reinitiated regular residents' meetings. We saw the minutes from these meetings, many of which were conducted on a one to one basis. People and staff also told us about weekly coffee mornings that took place. One person told us, "They do have meetings with us; they listen to what we say". We also saw the

minutes of staff meetings. These took place approximately once every two months. Staff told us that they were useful and that they felt their ideas and concerns were taken on board.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. When accidents, incidents or near misses occurred, these were documented using an incident form. They were investigated by the manager and a record was then sent to the provider on a monthly basis. The manager told us, "The company is moving everything to the electronic system so the quality assurance can be done centrally". He also shared examples of changes that they had made within the home in response to risks that had been identified.

The manager used a number of auditing tools to monitor the quality of the service. We saw monthly audits on health and safety and medication management, as well as quarterly compliance audits that were sent to the provider. There were also regular spot checks on staff that assessed their knowledge and competency in areas such as medication administration and food hygiene. We noted that any issues identified had been dealt with quickly and appropriately. We found that there was an effective system in place to monitor the quality of service provision and to respond to any new needs or issues.

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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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