Review of compliance

Charing Hill Limited Hillbeck Residential Care Home	
Region:	South East
Location address:	Roundwell Bearsted Maidstone Kent ME14 4HN
Type of service:	Care home service without nursing
Date of Publication:	September 2011
Overview of the service:	Hillbeck Residential Care Home is a 40 bed care home for older people who have difficulty managing aspects of their comprehension. The property has two floors, with a lift. Most bedrooms have en suite facilities and bathrooms with assisted baths are available. A garden is available to people who use the service, with staff assistance.

	Hillbeck Residential Care Home is located near the village of Bearsted, approximately three miles away from Maidstone.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Hillbeck Residential Care Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

We spoke with people who said they enjoyed their days at Hillbeck Residential Care Home. People told us they liked the activities co-ordinator and seemed to enjoy a good relationship with him.

People told us they felt safe at Hillbeck.

What we found about the standards we reviewed and how well Hillbeck Residential Care Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Care plans are maintained and kept up to date. However, they do not sufficiently reflect involvement of people or their relatives.

The risk of people falling is not properly assessed, managed, or mitigated to ensure that the risk for each individual is properly understood or their needs met.

Staff are not adequately trained in managing falls, and have not been made aware of a policy to manage falls. The lack of management systems to mitigate falls, and the lack of staff training leads to a high incidence of people falling.

Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The staff's insufficient understanding of the role of external agencies and how to report abuse placed people at risk.
Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The home appeared clean and tidy; however unlocked clinical waste bins were not acceptable. There was no evidence that the risk of legionella and unflushed water outlets was understood, or that a system was in place to manage that risk.
Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff have not received sufficient training to ensure that people receive safe and appropriate care and their health and welfare needs were met. Staff do not have the knowledge and skills to meet the care needs of the specific group of people they care for.

Overall, therefore, we found that there are areas of non compliance with this outcome.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with people who said they enjoyed their days at Hillbeck Residential Care Home. People told us they liked the activities co-ordinator and seemed to enjoy a good relationship with him.

Other evidence
We reviewed three care plans that contained information about the person's life before moving into Hillbeck and an overview of their likes and dislikes. The care plans contained up to date information about the health status of the person, and updates from clinicians were also included.

We heard from staff that care plan reviews were generally held without the individual or their families present. Relatives were free to review plans when they visited the home, and summaries were posted to them to sign in agreement. The care plans reflected this.

Some staff told us they had received some training in care planning, mainly within their NVQs. The training figures supplied by Hillbeck Residential Care Home showed 4% of staff had undertaken the provider's training in care planning.

One care plan we looked at included statements from staff about how they handled an incident. A person living at the home had become violent whilst in the dining area. Staff 'tackled him' and forcibly placed him in a wheelchair and returned him to his room. The person involved kicked out at a member of staff who was pregnant. The Head of Care

confirmed that no staff had received training on how to restrain people safely. They also confirmed that no action to protect people using the service had been put in place following this incident.

The clinical nature of people living at Hillbeck meant they were prone to experiencing falls. We looked at the care plans for two people prone to falling. These contained lists of when falls occurred and an overall falls assessment. We saw little evidence of how the risk of falls was mitigated, including any adaptations to the environment or individual circumstances. We saw evidence of external agencies carrying out assessments, these included a GP referral and input from the Parkinson's nurse. We saw no evidence of staff receiving training in falls management. We asked to see the falls policy, but staff did not know of any policy on falls. We spoke with staff who had not received training in carrying out risk assessments. We did not see evidence in care plans of any post-fall review, risk assessment, or changes to existing risk assessment following a series of falls.

On the day of our visit, two people experienced falls, one requiring paramedic attention. When asked, staff confirmed that no specific action or review would be taken following falls. There was no evidence of anyone being referred to a specialist falls clinic or documentation on why this was not considered as an option.

We spoke with the activities co-ordinator about how people spend their day. He described a range of activities open to people, including board games, bingo, and organised open days such as the summer fete. He explained how he tries to include those people who were less able to join in group activities. A new train set was recently installed following suggestions at a residents' meeting.
We were told that the home has had a minibus for about eighteen months. However, it has not been used as there were 'problems figuring out insurance and consent forms'. The activities co-ordinator had confirmed reduced admission fees with a local tourist attraction, but had not yet been able to use the minibus to take people out on visits.

Our judgement
Care plans are maintained and kept up to date. However, they do not sufficiently reflect involvement of people or their relatives.

The risk of people falling is not properly assessed, managed, or mitigated to ensure that the risk for each individual is properly understood or their needs met.

Staff are not adequately trained in managing falls, and have not been made aware of a policy to manage falls. The lack of management systems to mitigate falls, and the lack of staff training leads to a high incidence of people falling.
Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us they felt safe at Hillbeck.

Other evidence
When asked about safeguarding, staff told us that they would report concerns to the manager, or area manager. Overall, staff did not understand the role of external agencies in protecting people. Senior staff had received training in the Deprivation of Liberty Act, but this was not available to all staff. We spoke to staff who had not received training in safeguarding, and no-one was able to tell us which training course covered safeguarding. The training records given to us on the day were unclear. We were later advised that 16 staff had completed safeguarding training since January 2011.

Our judgement
The staff's insufficient understanding of the role of external agencies and how to report abuse placed people at risk.
Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We were not able to speak directly with people about this outcome during our visit.

Other evidence
The bedrooms, communal areas and corridors were clean and free from any offensive odours. The laundry room also appeared clean and tidy, and the laundry assistant was able to tell us the appropriate clothing wash temperatures for people who may be experiencing sickness.

The sluice room was cluttered and had boxes and buckets stored on the floor which would prevent proper cleaning. The floor of this room did not appear to have been recently washed. Examination gloves were being stored close to the sluice.

We saw two clinical waste bins outside the home in the car park that were open.

One store room had previously been used as a bathroom. The shower unit, toilet and sink were still in place, and connected to the water system.
Staff confirmed that these water outlets were not being flushed on a regular basis, and there was no system in place to ensure this happened. The staff we spoke to about this did not know of the potential risk of legionnella bacteria and unused water outlets.

Training records seen on the day were unclear; we were later advised that 61% of staff had received training in infection control over the past year.

Our judgement
The home appeared clean and tidy; however unlocked clinical waste bins were not

acceptable. There was no evidence that the risk of legionella and unflushed water outlets was understood, or that a system was in place to manage that risk. Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We were not able to speak directly with people about this outcome during our visit.

Other evidence
Evidence was found in a care plan referring to an incident as described under outcome 4. The Head of Care confirmed that staff had not received training on when it is appropriate to restrain people and how to do so safely. They also confirmed that no action to protect people using the service (i.e. risk assessments or staff training) had been put in place following this incident.

We asked for details of how many staff at Hillbeck Residential Care Home had received their mandatory training. A list was made available to us, but it was difficult to assess how many people's training was overdue, as there was no due date listed or accompanying list of how frequently staff should attend each course. Training records showed 21% of staff had attended training in dementia over the past year. We were told that training for care planning and risk assessments had recently changed and were now covered within one course.

Our judgement
Staff have not received sufficient training to ensure that people receive safe and appropriate care and their health and welfare needs were met. Staff do not have the knowledge and skills to meet the care needs of the specific group of people they care for.

Overall, therefore, we found that there are areas of non compliance with this outcome.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: The lack of sufficient training in safeguarding, and staff's insufficient understanding of the role of external agencies and how to report abuse placed people at risk. Overall, therefore, we found that there are areas of non compliance with this outcome.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Care plans are maintained and kept up to date. However, they do not sufficiently reflect involvement of people or their relatives. The risk of people falling is not properly assessed, managed, or mitigated to ensure that the risk for each individual is properly understood or their needs met. Staff are not adequately trained in managing falls, and have not been made aware of a policy to manage falls. The lack of management systems to mitigate falls, and the lack of staff training leads to a high incidence of people falling. Overall, therefore, we found that there are areas of non compliance with this outcome.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: The home appeared clean and tidy; however unlocked clinical waste bins were not acceptable. There was no evidence that the risk of legionella and unflushed water outlets was understood, or that a system was in place to manage that risk. Overall, therefore, we found that there are areas of non compliance with this outcome.	
Accommodation for persons who require nursing or personal care	Regulation 23	Outcome 14:

	HSCA 2008 (Regulated Activities) Regulations 2010	Supporting staff
	How the regulation is not being met: Staff have not received sufficient training to ensure that people receive safe and appropriate care and their health and welfare needs were met. Staff do not have the knowledge and skills to meet the care needs of the specific group of people they care for. Overall, therefore, we found that there are areas of non compliance with this outcome.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA