Hillbrook Grange Residential Care Home

Hillbrook Grange

Inspection report

Ack Lane East
Bramhall
Stockport
Cheshire
SK7 2BY

Tel: 01614397377

Date of inspection visit:
13 October 2016

Date of publication:
07 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hillbrook Grange Residential Care Home is registered as a charity and is administered by a Board of Directors. The service is located in the Bramhall district of Stockport and is close to local shops and other amenities. Stockport town centre, motorway network and public transport are easily accessible. Accommodation consists of single occupancy bedrooms located on the ground and first floors. There are two lounges, a quiet lounge/library and a dining room on the ground floor. The service can accommodate up to 41 people; at the time of the inspection there were 34 people living at Hillbrook Grange. Some of the vacancies had been planned to enable refurbishment of part of the service. Five of the bedrooms were allocated for people who require a 'rapid response' service which was a health-funded initiative to try to prevent people being admitted to hospital.

The service had a registered manager in post as required by a condition of registration. 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.

We undertook this unannounced inspection on the 13 October 2016. At the last inspection on 8 July 2014, the registered provider was compliant with all areas assessed.

We found there was inconsistency regarding the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The registered provider and registered manager had not always recorded when assessments of capacity and decisions made in their best interests had been made. We found there were people who may meet the criteria for DoLS but applications to deprive them of their liberty lawfully had not been made to the local authority. You can see what action we have asked the registered provider to take at the back of the full version of the report.

We found audit tools had been obtained and a plan was being developed to have a more systematic approach to quality monitoring. Currently the quality assurance checks were carried out in response to issues and needed development. We have made a recommendation that the registered provider and registered manager follow through with these plans and we will check them at the next inspection. We found there were systems for people to make suggestions and these were listened to and acted upon.

We found people who used the service were protected from the risk of harm and abuse. Staff had received safeguarding training and knew what to do if they witnessed abuse or if it was disclosed to them. People had risk assessments which helped to analyse any risk of harm, for example with moving and handling and falls and how it could be minimised. We found staff knew what to do in cases of emergencies and each person who used the service had a personal evacuation plan.

We found staff were recruited safely with all employment checks carried out prior to new staff starting work.

New staff received an induction and shadowed more experienced staff until it was felt they were competent to work alone with people. We found there were sufficient care staff on duty to meet people's current needs; there were ancillary staff for tasks such as activities, laundry, catering, domestic work, maintenance and administration so care staff could concentrate on looking after people.

We observed staff had a patient and caring approach. There were positive comments from relatives about the staff team. People who used the service and their relatives were provided with information on notice boards and in meetings. Staff treated people with respect and maintained confidentiality. Personal records were stored securely.

We found people received their medicines as prescribed and had access to a range of health care professionals in the community, when required to meet their health needs.

People enjoyed the meals provided to them. The menus enabled people to have choice and special diets when required. People's weight, their nutritional intake and their ability to eat and drink safely was monitored and referrals to health professionals took place when required for treatment and advice.

We found people had assessments of their needs and received care that was individualised for them. The care plans had some small gaps in how staff should care for people and we spoke with the registered manager who said they would address this with the staff team.

We found there were activities for people to participate in. These were provided in small and large groups. The activities helped to stimulate and include people and prevent them from being isolated. Some people told us they would like to see more activities on a one to one basis and tailored more effectively to people living with dementia. This was mentioned to the registered manager and they told us they would address this with staff.

The registered provider had a complaints procedure on display. People who used the service and their relatives told us they would feel able to complain and any concerns would be looked into and addressed.

We found the service was clean and tidy. Staff had cleaning schedules and equipment used within the service was maintained so it remained safe to use. The environment was suitable for people's needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were recruited safely and there were sufficient numbers on duty to meet people's needs. The registered manager told us they would review deployment of staff to make sure the main lounge is checked more frequently.

Staff received safeguarding training and knew what to do to keep people safe from the risk of harm and abuse. People had risk assessments to help guide staff in how to minimise risk.

People received their medicines as prescribed.

The service was clean and tidy and equipment used was safe and well-maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had not been fully applied. This meant some people who may meet the criteria for DoLS had not been assessed and could be detained unlawfully. The principles of MCA regarding assessing capacity and holding best interest meetings had not been followed for some people.

People liked the meals provided and their nutritional needs were met.

People's health care needs were met and they had access to community health care professionals when required.

Staff had access to induction, training and supervision which provided them with the skills, knowledge, support and confidence they required to care for people.

Is the service caring?

Good

The service was caring.

Staff were observed speaking to people in a kind and patient way and treated them with dignity. Staff respected people's right to privacy.

People were provided with information and explanations so they could make choices and decisions about aspects of their lives.

Confidentiality was maintained and personal information was stored securely.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and had assessments of their needs. Care plans had some gaps in information to guide staff when caring for them and the registered manager told us they would address this.

People had access to activities to help prevent social isolation and to ensure they were included and remained as active as possible. Some people felt there could be additional one to one activities tailored more effectively to the needs of people living with dementia; this will be reviewed by the activity coordinator.

There was a complaints process and people and their relatives felt able to tell management of any concerns so they could be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had the tools and a plan to monitor quality but a systematic approach had not been fully developed yet.

People were asked their views about the service and their suggestions were acted upon.

The culture of the service was described as open and focussed on the needs of people who used the service.

Hillbrook Grange

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 registered 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 13 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to the inspection, the registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We checked the PIR and also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning teams about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with five people who used the service and four people who were visiting their relatives. We spoke with the chairperson of the board of directors and another director, the registered manager, two senior care workers, one care worker, the cook and two visiting health care professionals.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as 25 medication administration records (MARs) and monitoring charts for food, fluid, weights, pressure relief and bathing. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These

included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the service.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe living at Hillbrook Grange and there was sufficient staff to support them. Comments included, "Yes [feels safe], the staff treat me well and always go the extra mile", "It's lovely here. I used to come for respite but now I'm here full time. They always come and close the windows each night", "Very safe; staff are very polite and friendly here", "Yes, we are treated properly", "There are staff available all the time", "Staff don't rush you", "They are there if I need them" and "Sometimes they can be short [staffed]." One person told us that sometimes they had to wait a little for staff as they needed two of them each time for support. When asked if their medicines were managed correctly, people said, "Yes, that's done well", "I have always found so" and "Yes, that's good."

Relatives were happy with the care people received. Comments included, "It's very good here", "Yes, we go away knowing she is well cared for and safer than in her own home", "We feel she is safe here", "Yes, absolutely [safe]; she has a sensor mat and they check her regularly. I used to worry every night as she wasn't safe at home but now I don't" and "There is definitely enough staff"

There were policies and procedures to guide the registered manager and staff about how to safeguard people from the risk of abuse or harm. Staff had completed safeguarding training and were able to describe the different types of abuse, the signs and symptoms that would alert them to concerns, and they knew how to refer the information to appropriate agencies. We saw staff completed risk assessments to identify if people who used the service had areas of concern that required monitoring. The risk assessments included skin integrity, falls, moving and handling, choking, nutrition, smoking, how to evacuate the person in an emergency and behaviours which could cause distress or harm to themselves or others. The information in the risk assessments and care plans provided guidance for staff in how to minimise risk.

We found there was sufficient staff on duty at all times to meet people's individual needs; the registered manager used a care banding tool to help them determine the staffing levels based on people's dependency needs. However, one relative told us there was not always a member of staff in the main lounge which could be an issue if people wanted to use the toilet. We observed on the day of inspection that there was a long period when staff didn't come into the main lounge. We spoke to the registered manager about reviewing staff deployment to make sure a staff presence was more readily available in the main lounge.

Staff rotas indicated there were six care staff on duty between the hours of 8am and 4pm and five on duty between 4pm and 10pm. There were three care staff on duty at night and a senior member of staff who completed a sleep in duty. The registered manager worked supernumerary to the staff rota. There were ancillary staff such as catering, domestic, laundry, administration, maintenance and an activity coordinator, which meant care staff could focus on care tasks. The registered manager told us there was a recruitment drive underway to establish a bigger bank of care staff that could be called upon when short-notice absences occurred; they were also recruiting for permanent day and night care workers and an additional laundry worker. The staff rota indicated there had been a reliance on agency workers to fill vacancies and absences; the recruitment of additional staff should reduce the need for agency workers and will provide more consistency. In discussions, staff confirmed there were enough of them to meet people's needs and

the registered manager obtained agency staff if required. Comments from staff included, "Yes, [enough staff], there is always agency staff if we are short" and "I think there is enough; we always get agency to cover if necessary."

Staff recruitment files showed us employment checks were carried out before new staff started work in the service. These included application forms to look at gaps, references from previous employers, disclosure and barring service (DBS) checks and interviews. DBS checks gives employers information about previous criminal convictions and whether the applicant has been barred from working in care settings. The recruitment process helped to ensure only suitable staff were employed to work with people who required 24 hour care. The registered manager told us they used staff from three local agencies to fill short notice gaps and holiday cover. Profiles of the agency staff were obtained, which provided basic information and some of them indicated the training they had completed. However, certificates were not included in the information sent from the agency. As some agencies fall out of the scope of registration and regulation with the Care Quality Commission, we discussed with the registered manager the need to confirm the training and competency skills of agency staff. The registered manager told us they would contact the agencies for clarification and copies of training certificates.

We saw medicines were managed appropriately and people received them as prescribed. Medicines were stored in a designated treatment room; there was a trolley secured to the wall and used when staff administered medicines to people. A fridge was used for those medicines requiring cold storage. Additional stock of medicines, not in day to day use was stored in locked cupboards and there was a specific cupboard for those medicines requiring more secure storage. The room was clean and tidy, and the temperature of the room and fridges were recorded to ensure medicines were stored in line with manufacturer's instructions. There was a controlled drugs record to indicate when these were given to people. Controlled drugs were those which required a higher level of security and monitoring. Staff recorded on people's medication administration records (MARS) when their medicines were received into the service and when given to them. There were some recording issues such as a discrepancy in the use of codes when people had their medicines omitted, some gaps in the MARs for topical products such as creams, and there was a lack of protocols to give staff guidance when medicines were prescribed 'when required' or as a variable dose. This was discussed with the registered manager and senior staff and they confirmed they would address the issues.

Equipment used in Hillbrook Grange was maintained and serviced at regular intervals. The equipment included hoists, stand aids, the passenger lift, profile beds, bed pan washers, call bells, the fire alarm system and fire-fighting items, and gas and electrical appliances. Water sampling was carried out to rule out the presence of legionella. The kitchen had a six monthly deep clean carried out by an external company. The servicing of equipment helped to ensure each item was safe and ready to use when required. A disaster recovery action plan had been devised to provide staff with guidance on what to do in cases of emergencies such as fire, flood, gas leaks, power failure or structural damage.

The service was clean and tidy. Staff had received training in infection prevention and control and we saw they had access to personal, protective equipment such as gloves, aprons, hand gel, soap and paper towels. Cleaning equipment was colour coded and the laundry had a commercial washing machine and drier. Skips for transporting laundry through the service had lids. Communal toilets and bathrooms had washable call bells so these could be easily cleaned and there were hand wash signs to guide people on good hand hygiene techniques. A health professional told us, "The home is very clean" and a relative said, "It's lovely and clean."

There were two designated sluice rooms and commode pan machines; some commode pans which had not

been checked following a wash in the machine, had been stacked to dry and required further cleaning; this was carried out on the day of the inspection. There were also some other minor cleaning issues which were addressed straight away.

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. We found staff were clear about how they would gain consent prior to carrying out care tasks and stated they never used any form of restraint or hand holding to restrict people during personal care. The registered manager told us they were aware of the need to document when capacity was assessed and also that any decision made in the person's best interest would need to be made in consultation with other people and agencies. However, there were instances when decisions had been made, for example when people were admitted to the service, when do not attempt resuscitation was considered, when sensor mats were in place and when staff held a person's cigarettes and lighter, but we could not see any capacity assessments or best interest records about the decisions.

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 saw the registered provider was working within the principles of the MCA and there was one person who the registered manager had applied for a DoLS and this had been authorised. We felt other people may meet the criteria for DoLS, for example one person required lots of support and monitoring and had a sensor mat in place to alert staff when they moved out of their bed. The registered manager is to assess their capacity and needs and make application for DoLS as required.

The lack of capacity assessments, recorded best interest meetings and the need to check out additional DoLS criteria amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

We saw most people who used the service were able to provide consent to day to day care. People who used the service confirmed they could make their own decisions. One person said, "We can get up and go to bed when we like; baths are arranged and I need support." The registered manager and staff had completed e-learning training in MCA and DoLS but it had been recognised that more in-depth training was required and this had been arranged for two dates in November 2016.

People told us staff knew how to look after them and contacted health professionals when required. They also told us they enjoyed their meals and had sufficient to eat. Comments included, "I would think so [see the doctor when required]; they have arranged the nurse to sort my legs out", "I see the nurse for my legs and they always arrange for the doctor if necessary", "Yes, I believe so [get the doctor when required], "Today the meal was poached eggs which was very nice", "There could be more variety of vegetables; the chef's not bad though" and "Shepherd's pie today was very nice; the meals are lovely. I prefer desserts; I would like more fresh fruit as it's usually sponge and custard."

Relatives told us they were happy with the care provided by the staff team. Their comments included, "Mum has dementia so she is not able to make her own decisions. Yes, they always get the doctor [when needed]", "They are very good and phone [the doctor] immediately; they respond to emergencies very well", "They keep us informed if the GP is called", "She eats well and is not losing any weight; the meals we've seen were beautifully presented and they all looked appetising", "The meals are nice", "As far as we know [staff well-trained]" and "Yes, the staff do seem well-trained."

We found people had access to health care professionals when required. These included GPs, district nurses, physiotherapists, community psychiatric nurses (CPNs), dietetic advice, speech and language therapists, emergency care practitioners, opticians and chiropodists. Staff recorded in each person's care file when they were visited and treated by health care professionals. Staff also supported people to visit outpatient appointments when relatives were unavailable. Staff were able to describe to us how they supported people to access health care professionals when they need to; there were aware of which people had special instructions from district nurses about health and personal care issues. Comments from health professionals included, "They always send information through – always report on people's condition" and "Staff are very knowledgeable, very capable and good at sorting out problems; there is good communication – excellent in fact."

We observed staff responded well to a medical emergency which occurred during the inspection. They acted quickly to check the person was not injured, made sure they had medical oversight before they were moved and ensured their privacy and dignity was promoted by placing a screen around them.

We found people's nutritional needs were monitored and met. People's nutritional status was assessed as part of the admission process and risk screening was carried out using a nationally recognised tool. We saw that any risks identified were recorded in care plans and people were weighed in line with risk analysis. Staff said, "We monitor people and can tell if they look unwell, check weight loss and if they are off their meals", "We weigh people monthly or weekly if necessary", "We recognise when sometimes people seem confused and they don't eat and drink" and "There is no person losing weight at the moment. If we have a major concern it's flagged up in handovers."

Menus were provided over a four week programme and were influenced by the seasons. The cook was aware of people's special dietary needs and provided meals to meet them, for example, pureed, lactose-free, gluten-free, fortified and diabetic diets. The menus provided a variable diet with choices and alternatives. Most people used the dining room to eat their meals; this was set out nicely with table and chairs for four people at each, table clothes, napkins, condiments and place names. The lunchtime experience was a social occasion and we observed people chatting with each other. Those meals observed on the day were presented well and people enjoyed them.

We saw staff had access to a range of training considered essential by the registered manager. This included falls prevention, fire safety, first aid, food safety, safeguarding, infection prevention and control and moving and handling. Those staff who administered medicines had completed training and other staff had completed training in the use of the nutritional screening tool, pressure area care and catheter care. There were some gaps in training but these had been identified by the registered manager and training courses in dementia awareness and how to manage people's behaviours which could cause distress or harm to themselves or others had been arranged for December 2016.

Staff told us they had sufficient induction and training and this enabled them to feel confident when supporting people. They confirmed they received one to one supervision meetings and annual appraisals with their line manager were about to start. We saw a sample of supervision records which indicated the

issues discussed and action to be taken. Comments from staff included, "Very good training here; I've recently done moving and handling, first aid, infection control and food hygiene. I'm down to do NVQ [National Vocational Qualification in care] at level three", "There is lots of training constantly" "I'm up to date with my training", "Support is good; all the staff get on well" and "The deputy manager is lovely, very nice and always there – very supportive."

The environment was suitable for people's physical needs. There were wide corridors, hand rails, grab rails in toilets and bathrooms, pressure relieving items and sufficient moving and handling equipment. There was some signage for bathrooms and toilets but as people develop more advanced stages of dementia, there would be a need for more pictorial reminders and signage. This was mentioned to the registered manager for future planning.

Good

Is the service caring?

Our findings

People who used the service told us staff treated them well and respected their privacy and dignity. Comments included, "Most definitely [staff caring]; they are always kind and really go that extra mile and it shows. They always ask us about everything like meals, activities and things", "They are always very polite", "They can't do enough for you; they are so caring and don't try to take over", "Staff are kind, considerate and gentle", "They are always very kind to me. I can do most things for myself but they are there if I need them" and "Staff offer to help with washing and dressing. They always knock on the door and always treat us with respect."

Relatives told us staff were caring, knocked on doors and respected privacy. Comments included, "We are very lucky to get a room; she is very happy sitting in her room watching the garden", "She is very happy here. The staff are compassionate; I have never seen one surly or off hand", "They are welcoming and friendly and treat everyone with respect and are not patronising at all. They go out of their way and that stands out; they are exceptional in fact", "They bent over backwards to get mum to a wedding and helped the family", "Most of the staff are [kind and caring]" and "They are lovely towards her." Some staff were singled out by relatives for their positive approach towards the people who used the service; there was one comment that some members of staff's approach towards some people with dementia could be more patient and reflect dementia care training. This was mentioned in feedback to the registered manager and they are to discuss with the staff team. Dementia training had been arranged for November and December 2016, which should help to reinforce good practice.

Visiting health professionals told us, "The standard of personal care is good. Privacy and dignity is respected and staff are very professional and have a lovely way with patients and relatives" and "Privacy and dignity is well-supported; they are very good staff and the standard of care is very good."

We observed positive interactions between staff and people who used the service. Staff were patient and spoke to people in a kind way. For example, we observed a kitchen assistant asking people about their lunch choices; one person told staff their eggs were not soft enough for them so they were quickly whisked away and replaced with a fresh supply. Staff checked the new plate of eggs was to the person's liking. One person got up to leave the dining table and staff observed they didn't have their frame so encouraged them to sit down until it could be collected for them; this was done in a positive way. We observed a very nice interaction between one member of staff and a person who used the service during a transfer from a chair to a wheelchair; the member of staff made sure the person didn't forget their handbag. We observed one episode of intervention between a member of staff and a person who used the service which could have been handled in a more sensitive way. We discussed this with the registered manager in feedback and they confirmed they would raise this with the member of staff in supervision.

Staff were attentive during activities, administering medicines, meal times and when giving people drinks and snacks in between meals. Staff ensured people had choices and could make their own decisions about meal selections; they also made sure people enjoyed a good selection of biscuits. Staff asked people if they would like second helpings of lunch. A member of staff administering medicines checked people had

sufficient to water to drink with their tablets and they discreetly checked if people required any pain relief.

We did note the fire alarm test occurred during lunch which wasn't the most appropriate time as this had the potential to affect the meal experience for people. Staff told us it was completed at lunchtime as most people were in the dining room and it minimised the risk of the fire doors closing abruptly and hitting them as they walked through them. The timing of the fire alarm was discussed with the registered manager to review; they told us they would discuss with maintenance personnel and find a more suitable time.

Staff understood the importance of respecting people's dignity and encouraging independence. In discussions they said, "We knock on doors and shut doors", "If people have a fall we put a screen around them", "Make sure we speak to people with respect", "Make sure you help them in private, for example, if they've had an accident", "We have to monitor care from agency staff; monitor the reaction from clients and think how I or my family would feel", "People are willing to do some things for themselves" and "Encourage people to do their own personal care and encourage them to walk; we don't want them to lose that. It's important to get the balance right and not push people too much; because of people's limitations, some people have good days and bad days."

All the bedrooms were for single occupancy and had sinks; some had en suite facilities of a toilet and shower. The single occupancy afforded people with privacy. Each room had a lockable facility and privacy locks were in place on bedroom, bathroom and toilet doors.

There was a reception area and staff greeted people who visited the service. There was a seating area near the reception and a room which could be used for relatives to see people in private. The room could also be used to hold reviews of people's care with health and social care professionals. There was a separate treatment room where health professionals could examine people and consult with them in private.

We saw people were provided with information. There were notice boards to indicate which activities were to be carried out each day. The menus were available and place names at the dining table as some people preferred to sit in the same place for each meal. Staff told this could change if someone preferred to sit elsewhere. There were leaflets in reception about the service, how to complain and advocacy arrangements. The food hygiene certificate and previous inspection reports were on display. Each person was provided with a 'resident guide and information' pack which included information about the service and staff, how to make a complaint and also contained a copy of the statement of purpose.

There was information about likes, dislikes and preferences in care files for how care should be carried out. This showed us people and their relatives had been involved in decisions about planning their care and support. Bedrooms were personalised and people and their relatives had brought in items to make them homely.

The registered manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. We found people's care files in daily use were held in the staff office where they were accessible but held securely. Staff records were held securely in lockable cupboards in the main office. Medication administration records were stored in the treatment room. The registered manager confirmed the computers were password protected to aid security. The registered provider was registered with the Information Commissioner's Office, which was a requirement when computerised records were held. We saw staff completed telephone conversations with health professionals or relatives in the privacy of an office.

Good

Is the service responsive?

Our findings

People who used the service told us staff were responsive to their needs. They said there were activities for them to participate in although some people said they would prefer more activities. Comments from people who used the service included, "I have a bath each week and see the hairdresser each week", "I'm fairly independent but they will help me to have a bath", "We had two this week [planned activities]; I enjoyed the singing and quizzes but not everyone does", "The garden is very pretty and we have squirrels and birds to watch; I like to sit in the lounge and have a good chat at mealtimes with the people on my table", "The activities are very good and the quiz makes you think; there is always reminiscence and we had a session on folding napkins", "It's ok really; sometimes there is not enough to do but I've enjoyed today" and "Once or twice there has been a fortnight with nothing to do; we don't have them [activities] all the time."

Comments from relatives included, "There are activities but she is happy to watch", One relative told us they felt there could be more activities tailored to people with dementia care needs.

Health professionals confirmed staff responded well to people's needs. They said, "Every person who needs a pressure cushion, has one; they will stand people up regularly [to relieve pressure and prevent sores occurring]" and "They put the patient at the centre of what they do."

Documentation showed us people's needs were assessed and any risk was identified. Most of the information about people's assessments and care plans were held electronically but there was also a paper file of specific information. We found people received care that was personalised to their individual needs although care plans could provide more guidance to staff about how this was to be achieved. In discussions, staff described care that was not included in plans and we observed care being provided that was similarly absent from the plans. For example, one person's care plan detailed the person was to be offered a bath but staff told us this didn't happen as they were awaiting a review by a health professional before bathing could be re-started. One person's care plan had limited information about their skin care whilst another required more guidance about the action required by staff to support them with behaviour that could be challenging. The small gaps in care planning was discussed with the registered manager who told us they would review them and update them where required.

People had some preferences for care indicated in plans such as the times of rising and retiring to bed, dietary needs and end of life decisions. There was also a 'This is me' document in each person's file and a pen picture about their past interests, family life, holidays, religion, previous occupation and likes and dislikes. We saw a 'residents questionnaire' had recently been completed which asked questions about preferences for where to have breakfast, bedroom or dining room, whether a shower or bath was preferred and what time of day for this. The personalised information helped staff to see the person as an individual.

We saw in minutes of a Board meeting in October 2016 that the registered manager had raised specific bathing needs for one person and identified the need for a wet room. The person's bathing needs were being met by the use on an en suite bathroom but the registered manager had identified this was not ideal and a wet room would benefit all the people who used the service; this was under review by the Board. We

observed that each person's bedroom door had a fire door stop which enabled them to have their door open when they chose but which would closure during a fire emergency. This responded to people's needs when they found it difficult to open their bedroom door as they walked with the aid of a frame.

We spoke with the activity coordinator who worked 40 hours a week Monday to Friday although they said they could work weekends if a specific activity was organised. The activities provided to people included, sing/songs, armchair exercises, quizzes related to memory, reminiscence and general knowledge, bingo, film and music sessions, card games, colouring and visiting entertainers. There was a dedicated hair salon and nail bar and a 'trolley shop' to enable people to make small purchases. There was also a computer set up for people to use and a facility to keep in contact with relatives via skype. There had been visits organised to garden centres, to Blackpool lights, to have fish and chips and a boat trip. The activity coordinator told us that when entertainers visited the service, there were drinks and nibbles provided to people to make it a social occasion.

We saw there were records of who had attended the activity sessions and noted there were no one to one activities with people. One to one activities may enhance the support provided to people living with dementia. This was mentioned to the registered manager and they told us they would speak with the activity coordinator and review activity provision so it could be provided in a more individualised way. There were notice boards and photo boards showing the trips and activities people had participated in. We observed an activity where the member of staff read a poem to people and had a reminiscence session about food and how bread used to be hand-cut. People joined in the discussion and talked about their own childhood experiences.

There was a complaints procedure displayed in the service and provided to people in the 'resident guide and information pack'. The procedure told people the registered manager and registered provider welcomed suggestions and complaints so they could respond to them promptly. There were names and contact details of the registered manager and a Board member and timescales for acknowledging and investigating complaints. People said they would be able to tell someone about concerns in the belief it would be addressed. They said, "We are told on admission how to make a complaint", "I would talk to the staff [about complaints]" and "I would write to the board [about complaints]." Relatives said, "We haven't needed to [complain]" and "I feel completely at ease to raise concerns; there have been a couple of queries about laundry but they were sorted out."

Requires Improvement

Is the service well-led?

Our findings

People who used the service told us they were able to see the registered manager and raise concerns. They told us they had meetings and were asked their views about the service.

Relatives confirmed they also attended meetings and the registered manager was available when required. Comments included, "It seems to be [managed well]. The deputy and seniors are very good."

We found there were the beginnings of a quality assurance system in place but this had not been fully developed. Some audits had been completed such as a selection of people's medication administration records, the environment, including health and safety checks and falls analysis but care plan documentation had not been audited since 2014, apart from monthly evaluations. A care plan audit would have helped to identify the gaps in information/guidance for staff that we found during the inspection. The registered manager had devised a new plan, had received audit templates, linked to the provider information return requested by the Care Quality Commission (CQC), and was due to start using these in the next few months. There had been external auditors for medicines, completed by the supporting pharmacy (only minor recommendations), a food safety audit by the local authority (rated five which was the highest possible score) and an infection control audit by the health protection unit (good score achieved).

There had been questionnaires in 2015 and 2016 for people who used the service and their relatives regarding views about the service. There had also been a specific survey about who would prefer a cooked breakfast, as this had been suggested in a letter from a person who used the service. We saw suggestions people made had been acted upon although the actions from audits and questionnaires had not been displayed for people to see. A member of the Board told us questionnaires had been re-designed to make them more accessible and easier to complete. A questionnaire for health professionals was due to be sent out in December 2016 and one was being designed for staff.

We recommend the registered provider and registered manager follow through with quality monitoring plans and the use of new templates and questionnaires. These would provide a more systematic approach to quality monitoring and will be checked at the next inspection.

The service was registered as a charity and had a Board of Directors. Full Board meetings were held every two months and there were monthly operations meetings with the registered manager. These were held to ensure the Board were kept informed of issues such as staffing, incidents, accidents and safeguardings and to review expenditure requests, for example for equipment or changes to the environment. A new Chair to the Board had been appointed the previous week and they planned to visit the service on a weekly basis. The Chair told us they were to start having chats with people who used the service, their relatives and staff during their visits and they would record any actions required. Another member of the Board visited the service twice a week and was available if people wanted to talk to him about any concerns.

The culture of the organisation was described by the new Chair as providing high quality, comfortable care to people with an open, friendly approach and relying on good communication systems. The Chair was

aware of their accountability and was open and honest in discussions and keen to recognise when improvements could be made. They told us they would happily come to Hillbrook Grange for care themselves and would be happy for any of their relatives to be admitted for care. A recent Annual General Meeting had been held at the service and members of the Board had met with relatives afterwards to enable them to make suggestions. There was a suggestions box in the reception area, which was checked regularly.

The registered manager confirmed members of the Board were always available for support and advice and they had no difficulty in raising issues with them. Staff confirmed the manager, deputy and senior care staff were available for support and guidance when required. We saw staff were provided with an employee handbook, which provided them with information about what was expected of them and what they could expect from their employers.

The registered manager was aware of their registration responsibilities in ensuring CQC received notifications of incidents that affected the health and welfare of people who used the service. During the planning of the inspection, we noted there had been a delay in CQC receiving some notifications. This was mentioned to the registered manager to ensure any such notifications were sent in to CQC in a timely way.

The registered manager had developed partnership working with health professionals attached to the Rapid Response service. Five beds within Hillbrook Grange were commissioned by health and had a rehabilitation focus and input from a multi-disciplinary team. A health professional told us communication was good between the service and the Rapid Response team and they worked well together.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not consistently acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This meant people had not always had their capacity assessed when decisions were made in their best interest. Applications to lawfully deprive some people who met the criteria for DoLS had not been made.