Care and Social Services Inspectorate Wales

Care Standards Act 2000

Inspection Report

Hillcroft Residential Care Home
11 Howells Crescent
Llandaff
Cardiff
CF5 2AJ

Type of Inspection – Baseline
Dates of inspection – Monday, 14 March 2016 & Thursday 31 March 2016
Date of publication – Friday, 29 April 2016

Summary

About the service

Hillcroft Residential Care Home is located in Llandaff, Cardiff and is operated by Farrington Care Homes Ltd. It is registered with Care & Social Services Inspectorate Wales (CSSIW) to provide accommodation together with personal care for up to 25 people over the age of 65 who have a diagnosis of dementia. The company has nominated a responsible individual but the home does not currently have a registered manager. This has been the case since 15 January 2015. We (CSSIW) were advised that a manager has been appointed.

What type of inspection was carried out?

We carried out a baseline inspection of this service in response to a number of concerns we received about the service. Concerns were raised by relatives of service users, the contract monitoring department of the local authority, Environmental Health and Public Health Wales. Contract Monitoring and Environmental Health/ Public Health Wales carried out their own recent inspections of the home.

We carried out two unannounced inspection visits to the home and considered the care of residents, the environment and staffing levels.

What does the service do well?

This inspection focussed on the areas of concern that we had been made aware of. We did not identify any areas of significant good practice.

What has improved since the last inspection?

We did not identify any significant areas of improvement since the last inspection of the service.

What needs to be done to improve the service?

The home is in breach of regulation 8 of the Care Homes Wales Regulations 2002 as the home does not have a registered manager. This is a serious matter and we have issued a non-compliance notice to the provider.

The home is in breach of regulation 24.-(2)(d). This is because we found that the carpets on the ground floor and stairs were worn and dirt ingrained in them. This is a serious matter and we have issued a non-compliance notice to the provider.

The home is in breach of regulation 13.-(3) because it was identified that the arrangements for infection control within the home were not satisfactory. This is a serious matter and we have issued a non-compliance notice to the provider.

The home is in breach of regulation 13.- (4)(a) This is because

(i) we observed that the door to the laundry was unlocked and the room unoccupied. Bottles of disinfectant were accessible to service users.

(ii) we observed that the faceplates of electrical sockets were damaged in three bedrooms.

The home is in breach of regulation 13.-(4)(c). This because the registered person

failed to ensure that people's pressure relieving equipment was functioning properly. This is a serious matter and we have issued a non-compliance notice to the provider.

The home is in breach of regulation 14.- (2)(a). This is because we found evidence that people's care plans and risk assessments were not being reviewed and did not reflect people's current care needs. This is a serious matter and we have issued a non-compliance notice to the provider.

The home is in breach of regulation 18.—(1). This is because there was little evidence that staff receive training appropriate to the work they perform. This is a serious matter and we have issued a non-compliance notice to the provider.

The home is in breach of regulation 18.—(1)(a) This is because the registered provider failed to ensure that there was sufficient staff on duty at all times to meet the needs of service users. This is a serious matter and we have issued a non-compliance notice to the provider.

The following additional actions should be considered and undertaken by the registered provider:

- immediate attention should be given to ensuring the privacy of a service user living in a bedroom where the lavatory is directly overlooked by another bedroom
- we recommend that mattresses should be enclosed in a waterproof cover
- the temperature in the conservatory should be regularly monitored to ensure that the room does not get excessively hot or cold causing discomfort to residents
- we observed that a wall in a resident's bedroom appeared damp due to water penetration. The cause of the damp wall should be investigated and if necessary remedied
- residents should be given opportunities for stimulation through leisure and recreational activities in and outside the home which suit their needs, preferences and capacities

Quality Of Life

Overall we found that that people are generally supported by a reliable and consistent staff team who form good relationships with them. Our observations indicated that the staff team have a good knowledge of the care needs of the people they support but this is not always documented in care plans and other service user records.

At our last inspection of the home in October 2015 we advised that care plans written for people living at the home should be reviewed to ensure that people's identified needs were documented and the staff clear about the support they need to provide. During our visit to the home on 14 March 2016 we examined three people's care records. Again we found that people's care needs were not being regularly reviewed or in some instances assessed. We noted that in one instance a manual handling and falls risk assessment had not been reviewed since 2013 even though the service user's mobility had recently declined which significantly increased the risk of falls. We found a similar situation with another resident. Their mobility had also declined but we could see no care plan or risk assessment advising staff as to how they should support the person. A recent referral to the local authority adult protection team concerned a resident who had experienced a number of falls over a three month period. It was identified that the risk of falls and measures to reduce identified risks had not been fully considered and information recorded until the day the person left the home to be admitted into hospital. One resident with a diagnosis of diabetes had not had their care needs associated with their condition assessed or recorded. All three care files we looked at contained care plans that had not been reviewed either monthly or when people's care needs had changed.

We considered the arrangements in place for the storage and administration of medicines. We examined the medicine administration records of all the service users living at the home. We found that generally these had been fully and accurately completed with just a few gaps. Care should be taken to ensure that the record is always completed otherwise it is unclear whether the resident has received their medicine or not. We noted that one person's pulse was taken before they received a particular medicine. Staff had sometimes recorded the pulse rate on the MAR which is good practice. We would recommend that the pulse rate is always recorded.

We had received concerns relating to the appearance of residents. It was suggested to us that people had been wearing the same soiled clothing for a number of days and male residents were unshaven. During our visits we met with residents and observed that a majority of people were wearing clean clothing and were well presented. We observed one resident to be unshaven. A recent entry made by a care worker in the daily notes stated that the resident should be shaved every day and that the person's family had commented adversely on their appearance. We were informed that the resident liked to be shaved by a particular carer but was resistant to other carers assisting. We suggest that the home share this type of information with family members so that they are informed and aware of some of the challenges the staff team might be facing. Other strategies to support the person with shaving and personal care should be considered.

We did observe on both of our recent visits that a particular resident was wearing stained clothing. We were advised that the person was resistant to changing their clothes. We could see no evidence of any attempts being made to routinely encourage the person to change. In discussion with the deputy manager they suggested ways in which this could be done. We would recommend that these situations are discussed as a staff team and any ideas, tactics or plans made to support the resident are documented in care plans and implemented.

During our visit on 31 March 2016 we observed in one resident's bedroom that a "repose" inflatable mattress was under-inflated placing the person at risk of developing pressure damage. We raised this with staff at the time. We were informed by a district nurse that they had visited the home on 6 April 2016 and also found the mattress to be under-inflated. The district nurse obtained a pump and inflated the mattress. All pressure relieving equipment including mattresses and cushions should be routinely checked to help ensure the wellbeing of residents and the prevention of tissue damage.

Activities are organised by members of the care staff team. However we could see no evidence of a structured activity programme. The local authority's contract monitoring officer who visited the home on 5 April 2016 was informed that when there are staff shortages activities are cancelled. He also found that activities tend to be offered to the same small group of residents and that those people with a greater level of dementia are not supported to engage in meaningful activities on a regular basis. It is important that all residents should be given the opportunity to regularly participate in leisure and recreational activities.

Quality Of Staffing

The majority of the staff team have worked at Hillcroft for many years and provide a good level of consistency for residents. During our visits we observed some very friendly and warm interactions between staff and residents and it is evident that in many cases residents regard care staff as friends.

Some staff working at Hillcroft have more than one role. For example a care worker might also cook or be put on the rota to organise activities. In some respects this flexibility can be useful especially when staff absences need to be covered. However, at times the total number of staff available has not been sufficient and despite the multi tasking abilities of staff there have been instances where there were too few staff to meet the needs of service users.

We examined the staff rotas for the weeks commencing 29 February 2016 and 7 March 2016. During the week beginning 29th February 2016 there were two days when there were only two care staff on duty between 8 am and 5pm. This was to meet all of the care needs of 20 residents. The morning time when people are getting up, receiving personal care, receiving medicines and eating breakfast is probably the busiest time of the day. Carers on duty would also be required to engage with any visitors such as district nurses or relatives of service users. Staff would also be required to supervise residents to ensure their safety. During our inspection visits we saw that some of the residents had high support needs due to their dementia related illness, other health concerns and in two cases people who were at the end of their life. Two care staff would have been insufficient to safely meet the needs of residents.

During the week commencing 7 March 2016, on one day a worker was on the rota to work in the kitchen and as a carer. They were also to take the lead in providing activities. On another day during this week there were only two care staff on duty between 8 am and 5 pm to meet the needs of around 20 service users. No member of staff was on the rota to provide domestic support.

It was reported to us that a majority of the staff absences were due to an outbreak of norovirus. However it is the responsibility of the registered provider to ensure that there are sufficient competent, skilled and experienced staff working at the care home in such numbers as are appropriate for the health and welfare of service users. This clearly relates to care staff but also includes domestic and catering staff to ensure that standards relating to food, meals and nutrition are fully met, and that the home is maintained in a clean and hygienic state.

Since our visits the registered provider has reported to us that additional staff are being employed and that agency staff could be requested should the need arise.

We did not consider staff training in depth during our visits to the home but we did ask to see a copy of any training matrix or other database recording the training that staff had undertaken. We were informed that this was not available on the day but could be sent to us. We did not receive this information. We later obtained feedback from other professionals that had visited the home. We were informed that they had found that training in areas such as infection control, medicine administration and moving and handling was either out of date or there was no evidence to demonstrate that staff had completed training. During our visit we were shown an email sent by the acting manager to a training provider requesting infection control, challenging behaviour and dementia care mapping training. This request seemed to be at least partly in response to the visit

from Environmental Health/Public Health Wales. The home lacks a staff training and development programme and this demonstrates a lack of oversight and management and puts both service users and staff at risk.

Quality Of Leadership and Management

People living at the home cannot be assured that the leadership and management of the home has been robust enough to fully ensure their safety or wellbeing. The home has been without a registered manager since January 2015. Since this time there has been at various times a temporary manager working at the home and two managers that only worked at the home for a short period of time. This lack of a permanent manager has had a detrimental effect on Hillcrest and various aspects of the day to day running of the home have been neglected. This included ensuring that care plans and risk assessments were reviewed and ensuring that the environment was safe. The lack of a permanent manager has also led to a breakdown in communication with some relatives of service users. We received concerns from a number of relatives who said that they could not obtain information from staff about their family member's health. In one instance a relative was advised to talk to the manager but they found that there was no manager on duty in the home that day.

Furthermore as we have discussed in the "Quality of Staffing" section of this report, we have observed that on some days staffing levels have been very low. Care staff have not been supported by the registered provider and they have been left to support residents as best they can. This is not satisfactory and there should be a policy and procedures in place to ensure that the home is always adequately staffed.

Overall the home appears to be managed in a reactive manner. There are not procedures in place for the organisation to proactively identify and address potential issues. The organisation reacts only when visiting professionals identify issues or areas of non compliance. This is considered to be poor practice and not responsive to the needs of people living at the home.

Quality Of The Environment

Overall we found that while many communal areas of the home had been redecorated the soiled carpets on the ground floor and staircases detracted from the work that had been completed. In addition during our inspection of the building we noted a number of issues that required attention and we were aware that officers from Environmental Health and Public Health Wales had recently inspected the home following an outbreak of Norovirus and made a number of requirements involving infection control. Their findings included a lack of soap and paper towels in resident bedrooms, that the staff team were not all trained in infection control and issues with the cleaning and disinfection of the environment.

We noted the following during our inspection of the premises:

- mattresses lacked covers
- electrical sockets in three bedrooms were damaged
- an electrical adaptor was plugged into an extension cable
- the floor of an en-suite was sticky
- in one bedroom the wallpaper was coming away from the wall
- the window in an en suite had clear glass and no curtains or blinds and could be viewed from a nearby bedroom
- there was no evidence of the temperature of the conservatory being monitored. The temperature should be monitored to ensure that the room does not get excessively hot or cold causing discomfort to residents
- the door to the laundry was unlocked and the room unoccupied. Inside the laundry we saw various bottles of disinfectant

The above list and the intervention of Environmental Health/Public Health Wales demonstrates a lack of organisation and management within the home. The registered provider should be auditing the premises to ensure that residents are living in a safe, well maintained environment. There should be in place a programme of routine maintenance and renewal of the fabric and decoration of the premises to ensure service users live in a safe, clean and secure environment suitable for their needs.

How we inspect and report on services

We conduct two types of inspection; baseline and focused. Both consider the experience of people using services.

- **Baseline inspections** assess whether the registration of a service is justified and whether the conditions of registration are appropriate. For most services, we carry out these inspections every three years. Exceptions are registered child minders, out of school care, sessional care, crèches and open access provision, which are every four years.

  At these inspections we check whether the service has a clear, effective Statement of Purpose and whether the service delivers on the commitments set out in its Statement of Purpose. In assessing whether registration is justified inspectors check that the service can demonstrate a history of compliance with regulations.

- **Focused inspections** consider the experience of people using services and we will look at compliance with regulations when poor outcomes for people using services are identified. We carry out these inspections in between baseline inspections. Focused inspections will always consider the quality of life of people using services and may look at other areas.

Baseline and focused inspections may be scheduled or carried out in response to concerns.

Inspectors use a variety of methods to gather information during inspections. These may include;

- Talking with people who use services and their representatives
- Talking to staff and the manager
- Looking at documentation
- Observation of staff interactions with people and of the environment
- Comments made within questionnaires returned from people who use services, staff and health and social care professionals

We inspect and report our findings under ‘Quality Themes’. Those relevant to each type of service are referred to within our inspection reports.

Further information about what we do can be found in our leaflet ‘Improving Care and Social Services in Wales’. You can download this from our website, Improving Care and Social Services in Wales or ask us to send you a copy by telephoning your local CSSIW regional office.

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Non Compliance Notice

Adult Care Home

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in CSSIW taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.cssiw.org.uk

Hillcroft Residential Care Home

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Date of publication: **Friday, 29 April 2016**

Quality of Life

Non-compliance identified at this inspection and action to be taken

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must ensure that residents care plans and risk assessments are reviewed each month or when needs change in order to reflect peoples current care needs.	27 April 2016	14.-(2)(a)

Evidence

At our last inspection of the home in October 2015 we advised that care plans written for people living at the home should be reviewed to ensure that people's identified needs were documented and the staff clear about the support they need to provide. During our visit to the home on 14 March 2016 we examined three people's care records. We found that people's care needs were not being regularly reviewed or in some instances assessed.

- There was evidence in a resident's daily notes that their mobility had significantly declined in recent months. We checked the person's care file and found that manual handling and falls risk assessments had not been reviewed since April 2013
- Daily records showed that another service user's mobility had recently declined as a result of illness. We found no evidence of an assessment or care plan being completed
- A resident with a diagnosis of diabetes had not had their care needs associated with their condition assessed or recorded
- A service user's mental health care plan had not been reviewed since 24 December 2015
- A resident's care plan regarding sleeping and night-time routines had not been reviewed since November 2015
- In one person's care records we saw a "Waterlow" assessment used to assess the risk of skin damage had not been completed since February 2012. The records were not clear as to whether this assessment tool was required
- Care plans in one resident's file had not been reviewed since August 2015
- All three care files we examined lacked evidence of regular evaluation and review

The impact on people living at the home is that they cannot be certain that their health, personal and social care needs will be identified and that care staff will support them appropriately and safely.

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must ensure that people's pressure relieving equipment is functioning properly at all times.	22 April 2016	13.-(4)(c)

Evidence

During our inspection visit to the home made on 31 March 2016 we observed that a "repose" air filled mattress was under inflated. We advised staff of this. In discussion with a member of the district nursing service on 7 April 2016 we were informed that that they had visited the home on 6 April 2016 and also found the mattress to be under-inflated.

The impact on people using the service is that if they require pressure relieving equipment then it should be used and maintained correctly otherwise there is a high risk of people sustaining pressure damage.

Quality of Staffing

Non-compliance identified at this inspection and action to be taken

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must ensure staff receive training appropriate to the work they perform.	29 April 2016	18.-(1)

Evidence

During our inspection visit on 31 March 2016 we requested a copy of the home's staff training matrix or other documentation to demonstrate that staff had completed relevant and required training. We did not receive this information.

A professional from the local authority contract monitoring department also requested similar information during their visit made on 5 April 2016. They noted that a training matrix was not available and that there was a lack of evidence of training in the staff files they examined.

Environmental Health/Public Health Wales visited the home on 18 March 2016. In their report they stated that the home was required to *"Put in place on-going infection control training and assessment for all staff and keep up to date records of attendance and competency."*

The impact on people using the service is that they cannot be assured that they are being assisted by competent people with the skills and knowledge to meet their care needs. Members of the staff team are placed at risk if they have not received the training and instruction they require to safely carry out their duties.

Quality of Leadership and Management

Non-compliance identified at this inspection and action to be taken

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must appoint a manager that is suitably qualified and experienced who must submit an application to CSSIW to be registered	16 June 2016	8

Evidence

Hillcroft Residential Care Home has been without a registered manager since 15 January 2015.

The impact on people who use the service is that they cannot be assured that the home is run in a manner that ensures that all aspects care of provision are considered and organised and that there are quality assurance systems in place to ensure the home's compliance with legislation**.**

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must ensure that there is sufficient on duty at all times to meet the needs of service users	22 April 2016	18.-(1)(a)

Evidence

We examined the staff rotas for the weeks commencing 29 February 2016 and 7 March 2016. During both of these weeks there were occasions when there were insufficient staff on duty.

On Thursday 3rd March 2016 there were three care staff on duty between 8 am and 2 pm to meet the needs of 20 residents.

On Friday 4 March 2016 there was no domestic worker on the staff rota.

On Saturday 5 March 2016 there were two care staff on duty between 8 am and 5 pm, one cook and a domestic worker.

On Sunday 6 March 2016 there was one care worker on duty between 8 am and 2 pm and two care workers between 2 pm and 5 pm. There was also a cook and a domestic worker on duty.

On Monday 7 March 2016 a care worker was also on the rota to act as cook. Three staff including the carer/cook were on duty between 8 am and 2 pm. Only two care workers were on duty between 2 pm and 5 pm. There was also a domestic worker on duty.

On Thursday 10 March 2016 there were three care staff on duty between 8 am and 2 pm and two care staff on duty between 2 pm and 5 pm. On this day there was a cook and a domestic worker on duty.

On Friday 11 March 2016 there were two carers on duty between 8 am and 5 pm. There was a cook on duty but no domestic worker.

On 9 March 2016 the manager of the home reported to CSSIW that there had been an outbreak of diarrhoea and vomiting which began on 29 February 2016. This was subsequently identified as an outbreak of norovirus. On 29 February 2016 eleven residents were affected and we were later informed that this increased to thirteen residents. (There were twenty people living at the home at this time.) The care needs of these people would have been considerable. The cleaning of the home would have been crucial during the outbreak. Environmental Health and Public Health Wales visited the home on 18 March 2016. They identified a number of areas that required attention including effective cleaning and disinfection of the care home environment.

During our inspection visits to Hillcroft made on the 14th and 31st March 2016 we observed that residents had high support needs due to their dementia related illness, other health concerns and in two cases people who were receiving end of life care. We observed that the people who were receiving end of life care were frail and required a lot of support to assist them with their personal care needs, eating and drinking and turning to prevent pressure damage. We observed a care worker assisting one person to eat a meal. This task was being carried out appropriately but provided an example of the considerable amount of time required by care staff to support the person. The person required turning and this was being carried out by two care staff. This demonstrates the need for the home to have staffing levels which reflect the care needs of residents.

One service user sustained eight falls between 11 March 2016 and 3 April 2016. A report of one of the falls completed by a staff member concluded, “staff to assist [service user] using the stair lift and walking at all times.” This is an example of the support a single resident requires in order to mobilise but which cannot be guaranteed when staffing levels are as low as they were at various times in March 2016.

We found no evidence of people’s dependency being monitored, evaluated and translated into staffing numbers but did note that people’s care needs were substantial.

Quality of Environment

Non-compliance identified at this inspection and action to be taken

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must ensure all worn and soiled carpeting in the home is replaced	29 April 2016	24.-(2)(d)

Evidence

During our inspection visits of 14 March 2016 and 31 March 2016 we observed that the carpets in the corridors on the ground floor and the staircases leading to the first floor were worn and soiled. The original lighter colours of the carpet are obscured in places by ingrained soiling.

The impact for people using the service is that they are not living in a well maintained and decorated environment. The heavily marked carpet creates a poor impression of the home and the people living there.

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must ensure all parts of the home are free from hazards to people's safety.	20 April 2016	13.-(4)(a)

Evidence

During our inspection visit made on 31 March 2016 we observed that three electrical sockets in three different bedrooms were damaged.

We also observed that the door to the laundry was unlocked and inside the laundry we observed bottles of disinfectants stored on a windowsill.

The impact for people using the service and members of the staff team is that it places them at unnecessary risk of electrocution. And service users and visitors to the home could gain access to the chemicals stored in the room and ingest them. The home is registered for people with cognitive impairments and it is possible that they might mistake the toxic contents of a bottle for a drink.

In April 2014 we carried out an inspection of the home in response to an incident where a service user had poured bleach onto their breakfast cereal thinking it was milk. The incident occurred in the dining room and the bleach stored in an easily accessible kitchenette. In our inspection report we also noted that the laundry was unlocked and there was easy access

to chemicals. Our observation of the laundry being unlocked demonstrates the home has failed to take action to reduce the risk to services users, members of the public and staff.

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
The registered person must improve the arrangements for infection control within the home.	27 April 2016	13.-(3)

Evidence

Environmental Health and Public Health Wales visited Hillcroft following an outbreak of norovirus notified on 29 February 2016. They informed the registered provider of the home that infection control policies and procedures needed to be reviewed to ensure their effectiveness in the control and prevention of gastrointestinal infections within the home. This included effective hand washing and hygiene practices of staff, facilities for hand washing, effective cleaning and disinfection of the home and ensuring that staff were trained and competent.

The impact on people living at the home is that without measures in place to prevent, protect against and control the spread of illness at the home there is a high risk of residents suffering significant harm.