



## Inspection Report on

**Hillstone House**

**59 Colcot Road  
Barry  
CF62 8HL**

## **Date Inspection Completed**

06/08/2024

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## About Hillstone House

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Amethyst Healthcare Ltd
Registered places	8
Language of the service	English
Previous Care Inspectorate Wales inspection	<a href="#">3 August 2023</a>
Does this service promote Welsh language and culture?	This service is working towards providing an 'Active Offer' of the Welsh language and demonstrates a significant effort to promoting the use of the Welsh language and culture.

### Summary

People are mostly content with the care and support they receive. Personal plans and risk assessments are partly reflective of people's needs and preferences. Care staff complete a range of core training topics but competencies for many care staff are incomplete which puts people at risk. People access health services and have contact with visiting health care professionals. People are sometimes supported to do things they enjoy but the insufficiency of care staff limits the opportunities available to individuals. People like living in the home and get on well with each other. Representatives are complimentary about the friendly and welcoming care staff.

Leadership and management at the service is consistent, however previous improvements in quality monitoring and governance has not been sustained. Auditing is failing to identify issues which impact on the care and support people receive. Therefore, the service is missing important opportunities to act in areas such as health, the environment, staffing, record keeping, administration of medication, and the sufficiency of supplies. The provider is not delivering a service in line with regulatory requirements and the statement of purpose (SoP). The multiple issues identified at this inspection is having an impact on people's health and well-being, and we have therefore issued a priority action notice. The provider must take immediate action to address the issues.

## Well-being

People remain settled living in the home, and they develop sound friendships with those they live with. Individuals receive support from friendly and kind care staff. Representatives told us they receive a warm welcome and people have regular visitors from those who are important to them. We found a pleasant atmosphere when people are together in the communal areas. Some day-to-day outcomes are met but we found people experience missed opportunities to have all their needs met in-line with their personal plan. This is because the service is unable to sustain the appropriate levels of staffing arrangements and shift patterns socially restrict people.

People make some choices on a day-to-day basis, but we found these are limited by the deployment of care staff, the set routines of the home and the lack of engaging activities to meet people's hobbies and interests. We found people are accustomed to going to bed early, and spending considerable times in their bedrooms when there is "*Nothing planned.*" People told us they would like to do more, and care staff try to accommodate people as best they can, but they require more guidance, support and resources to meet individual needs.

People do not live in an environment in which they are always protected from harm. We found inadequate oversight of health and safety, infection prevention control, fire safety, food safety and controls of substances hazardous to health (COSHH). All of which put people at moderate risk.

People's physical well-being is compromised because the oversight of daily records and medication management is ineffective. This means people are at risk of not receiving timely interventions and care and support from suitably competent staff. Not all care staff are confident and competent in key areas, this means people's right to receive good personal care, safe moving and handling and 'as required' medication is compromised, especially at night.

## Care and Support

People have control over some aspects of their day-to-day life, but this is dependent on the sufficiency of care staff. People told us they are happy and settled in the home but would enjoy more meaningful activities. The availability for people to take part in hobbies, interests and social events is extremely limited, and we found a lack of opportunities for people to experience fulfilling and stimulating engagement in-line with their personal plan.

People receive the right care and support most of the time, but not consistently. The service is failing to provide people with enough care staff who are qualified, skilled, trained and competent 24 hours a day. We found people's needs are not always met due to the limitations of some care staff where the service has failed to provide training and to monitor their competencies to administer medication, and safely use manual handling equipment. We observed some poor practice of care staff when moving a person whilst seated.

Personal plans and risk assessments are in place and are partly reflective of people's needs but some key information is missing, meaning care staff are not always fully informed. When the personal plan is reviewed, we cannot be assured people and their representatives participate. Most representatives told us they are not involved in review meetings but kept up to date informally.

People access health services and receive support to attend appointments. Some people receive home visits from health care professionals on a regular basis. Referrals are made for people as and when needed and specialist advice from health professionals is sought. However, we were told the service does not consistently follow guidance to keep accurate care records. Management and monitoring of care records is not effective, meaning people are not receiving timely interventions to improve their health and well-being. The service is responsible for the safe management of medication. Policies and procedures are in place, but the service is not currently operating in-line with it. We found medication auditing unsatisfactory. People are unable to always access medication because more than half of care staff are not fully trained to safely administer them, this includes emergency medications.

Care staff receive infection prevention control training, and a policy is in place to protect people from harm. But we found insufficiency in supplies of personal protective equipment (PPE) to effectively protect people from cross contamination during personal care routines. There is a lack of day-to-day oversight of care staff practice to ensure good infection prevention control measures are followed.

The multiple issues identified at this inspection is having an impact on people's health and well-being, and we have therefore issued a priority action notice. The provider must take immediate action to address the issues.

## Environment

People live in an environment which partly meets their needs, and some told us they are happy. The home is bright, pleasantly decorated and free from trip or fall hazards. The occupied bedrooms are individualised, in styles and colour schemes of the person's preference. We found the respite bedrooms did not have the same care and attention, with ill-fitting bedding, ill-fitting curtains and a lack of furniture to make the room comfortable and meet the regulatory requirements. The communal areas are sufficient for people to socialise together. The home offers an additional comfortable lounge for people to receive visitors, however this is currently used as a storage room for equipment. We are told people's privacy is not always maintained as some health treatments take place in the communal area.

We found the appearance of the home to be clean and hygienic, but there is a lack of essential cleaning products and suitable equipment to be assured cleaning regimes are effective. The limited use and availability of PPE, and insufficient monitoring of infection prevention control practice puts people at risk. People are at risk because we found poor management of hazardous cleaning fluids and a disregard of COSHH legislation. We observed areas of the home which should be locked to keep people safe were not secure on each inspection visit.

Records relating to food safety during inspection of the kitchen area were not available. We found unsafe food storage practices and insufficient supplies of fresh produce, a lack of healthy snacks and a low stock of staple food items like bread and cereals. A later inspection by the Foods Standards Agency found the home to be meeting their regulatory requirements.

People access equipment to help them to achieve their daily outcomes. We found servicing records and equipment in good order. Firefighting equipment is in order, and a basic fire risk assessment is in place. We found internal checks of fire safety systems are incomplete, fire drills out of date and records are inadequate. New staff are yet to experience a fire drill and we cannot be assured all staff are competent in evacuation procedures and are aware of people's evacuation plans. Auditing of the environment is ineffective in identifying and reducing these risks and the provider has been unable to sustain the good progress observed at the last inspection. The multiple issues identified at this inspection is having an impact on people's health and well-being, and we have, therefore, issued a priority action notice. The provider must take immediate action to address the issues.

## Leadership and Management

There are no changes to the management and responsible individual (RI) of the service since the last inspection. We did not see a continuation of the previous improvements with quality monitoring, auditing and oversight of the service. Regulatory quality monitoring and auditing activities do not sufficiently identify key areas of improvements in the delivery of the service in all themes. This significantly impacts on people's care and support outcomes. The RI produces a quality-of-care review but governance information available at the service is not up to date. We cannot be assured the management and provider are reliably informed of actions to take to improve the service and sustain regulatory requirements. The RI visits the service to speak with people and staff, and to sample records across the service. But we found records of the visits do not go far enough to identify omissions in various care records, staff sufficiency and competencies. Quality auditing is not identifying discrepancies between various records relating to accidents, incidents, concerns, complaints and safeguarding issues. The regulator is not consistently informed of notifiable events which is a regulatory requirement. Oversight of the environment falls short in recognising and acting upon failings observed at this inspection.

The service follows appropriate recruitment processes, and care staff hold disclosure and barring certificates (DBS). Those who are eligible are registered with Social Care Wales, the workforce regulator. A few care staff hold a relevant social care qualification, but we found several staff, including some in a position of authority, across the service remain unqualified which is not in-line with the SoP. The service experiences a comparatively high staff turnover which impacts on the continuity of knowledge, skills and competency. Supervision records evidence care staff receive regular supervision and most told us they receive the right level of support and guidance. Management is not completing competencies with all care staff, and we found poor practice with moving and handling, medication administration and infection control.

Care staff receive training to understand their roles and responsibilities to safeguard people from harm and abuse. Policies are in place relating to safeguarding, whistleblowing and how to raise a concern or complaint. Some staff are confident their concerns would be acted upon, but others lack confidence in the service to take effective action. Records relating to complaints are incomplete and records of concerns are not retained. We are not assured the current ways of working address key issues with transparency and accountability. The multiple issues identified at this inspection is having an impact on people's health and well-being, and we have therefore issued a priority action notice. The provider must take immediate action to address the issues.

### Summary of Non-Compliance

Status	What each means
<b>New</b>	This non-compliance was identified at this inspection.
<b>Reviewed</b>	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
<b>Not Achieved</b>	Compliance was tested at this inspection and was not achieved.
<b>Achieved</b>	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

### Priority Action Notice(s)

Regulation	Summary	Status
57	The provider has failed to have suitable arrangements in place to reduce and manage risks to health and safety.	New
6	We cannot be fully assured the service is provided with sufficient care, competence and skill, having regard to the statement of purpose to ensure the service operates safely and effectively.	New
34	The service is unable to ensure sufficiency of qualified, skilled and competent staff at all times to support people to safely achieve their personal outcomes.	Not Achieved



Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection.

Area(s) for Improvement		
Regulation	Summary	Status
55	The service provider has failed to ensure sufficient supplies are available of a suitable type to deliver the service effectively to meet the needs of people.	New
58	People are at risk of not receiving their medication correctly and safely by trained and competent staff, and ineffective auditing of medications placing people's health and well-being at risk.	New
59	The service provider has failed to maintain accurate and up to date records which could impact on their ability to keep people safe from harm.	New

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