Hillend View
Care Home Service

14 Airdrie Road
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Type of inspection:
Unannounced

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Service provided by:
Hillend View Limited

Service provider number:
SP2011011741

Service no:
CS2011304898

About the service

Hillend View is a registered care home for up to 80 adults with mental health problems, associated disabilities and health issues. There were 78 people living in the service at the time of our inspection.

The service is an independent care home, set in extensive grounds close to the village of Caldercruix and the town of Airdrie in North Lanarkshire. It has good access to bus and rail links to both Edinburgh and Glasgow.

The service is provided in two buildings known as H1 and H2. The older building is H1 and has 45 bedrooms, with five public rooms and two dining rooms, and H2 accommodates up to 35 people. This building has four small units, lounges and dining rooms. It also has an assessment kitchen and cinema/sensory room.

The aims and objectives of the service state:

'Hillend View is an independent provider working with men and women requiring:

- care and support; and
- rehabilitation services.

It aims to:

- maximise their quality of life;
- maintain good mental health;
- promote social inclusion;
- and skills for a sustainable discharge into the community where appropriate which enables people to continue their recovery.'

What people told us

There were some positive comments from people, including:

"Some good times."

"All staff are exceptionally kind."

However, other comments identified areas for improvement:

"Feels like a prison."

"I don't like it here."

"Tinned fruit once a week. No fresh veg, only frozen."

"Would like more exercise."

"Rubbish. No activities."

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	1 - Unsatisfactory
How good is our leadership?	2 - Weak
How good is our staff team?	1 - Unsatisfactory
How well is our care and support planned?	2 - Weak
How good is our care and support during the COVID-19 pandemic?	2 - Weak

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 1 - Unsatisfactory

Some staff demonstrated knowledge of people's preferences, choices, life histories, likes and dislikes. Despite this, some people who use the service experienced poor outcomes, care that was not safe and a lack of person-centred support. People's independence, dignity and privacy were not consistently considered or promoted. This compromised their human rights.

While some staff demonstrated skill in managing people who experienced distress or upset, we observed long periods of time when people were sitting in lounges or bedrooms alone. This included people who live with communication impairment and had no way to summon assistance; the nurse call system was not accessible for everyone. For example, a person who required support with continence needs was unable to get prompt help because of the location of the call system. This compromised the person's dignity, safety and wellbeing, and physical needs were not met. This area of practice was subject to an improvement notice which we issued to the service on 23 August 2021.

There was a lack of activities taking place. Only one activity coordinator was employed to support 78 people in two buildings. Positively, an additional worker was due to start soon. Care staff were very busy with personal care tasks and were unable to engage in meaningful exchanges or support activities for residents. A requirement about staffing levels was included in the improvement notice, issued to the service on 23 August.

The information available to staff about people's mental health needs and the agreed way to manage needs was insufficient to promote positive outcomes. Mental health needs did not appear to influence the support people received nor how they spent their time. Links to health promotion, recovery and harm reduction

specialist services in the community would be beneficial. This area of practice is now subject to an improvement notice, which we issued to the service on 23 August.

There were links to some community health professionals, including the care home liaison nurse and dietitian. However, people were not referred to other specialists when this may improve outcomes. For example, tissue viability nurses or continence specialist support would be beneficial in the assessment and treatment of people. This area of practice is now subject to an improvement notice which we issued to the service on 23 August.

The service provided care to people from 18 local authority areas and this resulted in a lack of access to treatment pathways, usually accessible via NHS community mental health teams. Managers told us they had attempted to establish links with local teams but were unsuccessful. The service employ a private psychiatrist who will retire soon; this will leave residents without a responsible Approved Medical Practitioner (AMP). The provider continues to work on a plan to access local NHS services for all residents.

People lacked physical, social, emotional and mental stimulation. Residents were not routinely referred to NHS professionals, such as occupational therapists who can support mental health needs, and have expertise in developing maintenance or recovery plans and goals. This area of practice is now included in an improvement notice issued to the service on 23 August.

Many risk assessments were inaccurate. This included assessments for weight loss, skin integrity and the risk of falls. Therefore, personal plans lacked the right information to identify risk. Personal plans also contained insufficient detail about guardians or appointees and their powers. We concluded that the service did not effectively manage risk and that this had a negative impact the health, welfare and safety of some individuals. This area of practice is now subject to an improvement notice which we issued to the service on 23 August.

Many people said they enjoyed the food and recent consultation took place with people to inform menu planning. Some staff had an awareness of people's preferences and specific dietary needs. External professionals were contacted when people required specialist support.

We also observed unsatisfactory support when people had needs in relation to nutrition and hydration. For example, there was limited access to drinks between meals, even when people were at risk of dehydration or weight loss.

When there was a need for food and fluid monitoring, this was not consistently evaluated. Risk was exacerbated by inaccurate record keeping. Practice did not promote positive health and wellbeing outcomes for people.

At times, the dining rooms were noisy and busy. There was a significant contrast between a positive dining experience in some areas and poor experiences in other areas. The provision of adaptions could support people to eat independently. For example, the use of a plate guard promotes independence, which impacts on the person's self-esteem.

People were directed to a mealtime 'sitting' which was designated according to the texture of food they require to eat. This was unsatisfactory practice which was established to support the routines of the home rather than the preferences of people who use the service. This area of practice is now subject to an improvement notice which we issued to the service on 23 August.

Although the service had an assessment kitchen, this appeared to have limited use. People had insufficient opportunities to be involved in purchasing, growing, preparing and serving their own food. People should be fully supported to gain and maintain their skills and independence.

How good is our leadership? 2 - Weak

There were limited opportunities for people to be involved, or express their views, about life in the home. Some people said they were not listened to. Consequently, they were frustrated about limited choice and control over their lives. There was limited evidence about how people's views contribute to decision making.

There was a lack of care and welfare governance, including audit. This contributed to poor outcomes for people's mental and physical wellbeing. For example, we spoke to people who were disengaged and lacked motivation. Their goals and aspirations were not identified or recorded.

The development of a service improvement plan would help to establish priorities and ensure that people benefit from a culture of continuous improvement. (See requirement 1). Similarly, a revision and development of the aims and objectives of the service would support improvement. (See area for improvement 1).

The environmental audits that were in place do not address key aspects of the environment, including the assessment of flooring, furniture, soft furnishings, repairs and maintenance. Effective quality assurance systems and processes need to be embedded to ensure that recent improvements continue and that the environment remains clean and well maintained.

Staff practice must be in line with current best practice guidance. (See area for improvement 2).

Requirements

1. By 25 November 2021, you must ensure that people who use the service experience a service which is well led and managed and which results in better outcomes for them because of a culture of continuous improvement, including robust and transparent quality assurance processes. This must include, but is not limited to:

(a) effective audit and analysis of information through the use of an improvement model which makes a difference to people who use the service;

(b) specific, measurable, achievable, realistic and time-framed actions are identified in a plan which is developed to address the areas of improvement identified in audits and by people who use the service; and

(c) review of planned action to be undertaken to ensure staff are accountable for and carry out required remedial actions.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'I experience high-quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11);
'I use a service and organisation that are well led and managed.' (HSCS 4.23); and

In order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations Scottish Statutory Instrument 2011 No 210, Regulation 4(1)(a).

Areas for improvement

1. The aims and objectives of the service should be reviewed in consultation with people who use the service. People should be involved in the review to ensure these are written in an outcome-focused and measurable way.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'I can be meaningfully involved in how the organisations that support and care for me work and develop.' (HSCS 4.6);
'I experience high-quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11); and
'I use a service and organisation that are well led and managed.' (HSCS 4.23)

2. Effective quality assurance systems and processes should be put in place in line with current infection, protection and control guidance, to ensure the environment is well maintained and clean and that staff practices is in line with current guidance.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'I experience high-quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11);
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.' (HSCS 4.19); and
'I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment.' (5.22).

How good is our staff team? 1 - Unsatisfactory

We observed warm and kind relationships between some staff and residents. We found that staff were busy and constantly engaged in tasks with limited time for meaningful engagement and support. There were insufficient staff working in the care home.

The staffing levels across the home were determined by a dependency assessment, yet we observed people were unsupervised for long periods of time, in areas where falls and accidents occurred. The layout of home H1 did not allow staff observations on the two separate floors.

There was no evidence that staff rotas were reviewed to take account of people's changing health needs. The staffing mix , skill set and deployment of staff did not take account of the complexity of care and support needs. This area of practice was subject to an improvement notice which we issued to the service on 23 August.

The majority of staff were not trained in mental health diagnosis or treatment, nor knowledgeable about recovery-focused therapy. This led to support that was not evidence-based, focused on recovery and risk management.

There were two mental health nurses (RMN) to support 77 residents. Other nurses and carers had no mental health experience. The impact of two RMN nurses on practice was insufficient.

Staff told us they were interested in learning more about mental health but lacked support and direction. There was no training matrix for staff nor an effective analysis of training requirements for the service or individual staff. Training was limited and did not reflect the needs of current residents.

Staff lacked the right knowledge, competence and development to support people in line with their capacity for improvement. This area of practice is now included in an improvement notice issued to the service on 23 August.

How well is our care and support planned? 2 - Weak

People have a wide range of care needs, including those with permanent incapacity and people with severe and enduring mental illness. Many would benefit from a recovery-based treatment plan. Care plans provided no evidence of an enabling approach based on strengths or outcomes. Consequently, people did not receive the care that was right for them. Mental health care plans lacked detail and were not outcome-focused. There was limited information about the management of stress and distressed reactions. People's changing needs were not recorded.

There was a lack of input from specialist mental health professionals to support the development or review of plans. There was a lack of understanding of mental health diagnosis, treatment and rehabilitation. This area of practice was subject to an improvement notice, which we issued to the service on 23 August.

We concluded that care plans were lengthy and included some detail about how people want to be supported and information about likes and dislikes. There were good life stories included in some plans. However, people were not regularly involved in developing, reviewing or agreeing their care and support plans, or in identifying achievable goals.

The service had started the process of changing and shortening the plans, which need to be person-centred and outcome-focused, to meet health and wellbeing needs.

Anticipatory care plans lacked specific detail to reflect people's wishes and preferences. Anticipatory care planning should provide an opportunity for people to fully express their wishes and preferences when there is a deterioration in health. (See area for improvement 1).

Reviews of the care plans should take place six-monthly but did not happen for everyone. People and those who are important to them, or who have legal authority, should be involved in shaping and influencing planned care and support. This area of practice was subject to an improvement notice which we issued to the service on 23 August.

Areas for improvement

1. People's wishes and choices should be recorded in their Anticipatory Care Plan. This should included detail of how and where the person wants treated or supported in the future. Alternatively, the plan should

include information when the person declines to document care choices and wishes at the end of life.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'My personal plan (sometimes referred to as care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.' (HSCS 1.15): and
'I am supported to discuss significant changes in my life, including death and dying, and this is handled sensitively.' (HSCS 1.7).

How good is our care and support during the COVID-19 pandemic? 2 - Weak

The service followed the principles of "Open with Care" guidance. People were also supported to stay in touch with family and friends using various methods, including electronic technology.

Essential visits were provided throughout the pandemic when people were near the end of life, or when people experienced stress and distressed reactions that were reduced by visits from family and friends.

A relative told us about their confidence in the manager and staff and an approach which supported a resident's health needs. Nonetheless, the relative also expressed concern about the limited provision of planned activities. We comment on this under "How well do we support people's wellbeing?" This area of practice was subject to an improvement notice which we issued to the service on 23 August.

The information included in care plans did not always reflect the support that was required. We comment about this under "How well is our care and support planned?" This area of practice was subject to an improvement notice which we issued to the service on 23 August.

On 5 and 10 August, we issued letters of serious concern to the service because of significant weaknesses in infection prevention and control (IPC) practice. We were concerned about inconsistent staff practice, cleanliness and the state of repair of the home. The home was not cleaned in line with best practice guidance and not all bedrooms had soap provided to promote essential handwashing.

We found some bedrooms and communal areas were not clean; others were untidy. The majority of fabric chairs were dirty and stained. Some mattresses required to be cleaned or replaced. There was extensive damage to woodwork and doors which prevented effective cleaning and increased the risk of transmission of infection.

During this inspection, we followed up the areas of concern. Improvement was evident. New tables and chairs were purchased and woodwork and doors were newly painted. A significant number of replacement items of equipment and furnishings were requisitioned but not yet delivered. The home was clean and an environmental audit was started by the manager. Further work was required to some areas of the building which need refurbishment.

An additional staff room was created to avoid the need for staff to enter both buildings. Government guidelines were followed to provide regular testing for staff and visitors. Staff were aware of the procedures and were compliant with guidelines.

We viewed the laundry area and the systems to manage laundry. There were designated clean and used laundry areas, and staff were aware of good laundry management to minimise risks.

There was a good supply of personal protective equipment (PPE). Access to PPE and disposal bins was not always located at the point of use. During the inspection, the provider took action to locate PPE stations and bins throughout the home.

We observed inconsistent hand hygiene, which increased the risk of infection for people living in the care home, and staff. Not all bedrooms had liquid soap and paper towel dispensers to facilitate hand hygiene, and there was limited availability of alcohol-based hand rub (ABHR). The provider took action to provide additional soap dispensers and increased the availability of ABHR. This improved staff practice.

Staff received some training about IPC but there was no direct observations of their practice. Staff would benefit from additional IPC training and direct observation of their practice. (See area for improvement 1).

We comment about staff training needs under "How good is out staff team." Staff training and practice were subject to an improvement notice which we issued to the service on 23 August.

To avoid confusion, care and domestic staff need clearer guidance about their responsibilities for cleaning equipment, in line with Public Health guidance.

Cleaning schedules and management overview of the environment also need improved to provide assurance about effective cleaning. (See area for improvement 2).

Social distancing was observed in some communal areas to reduce the risk of infection transmission. However, during mealtimes, in one building, social distancing was not observed. We concluded that the available floor space was insufficient for the number of people using the area. We comment about the dining experience under "How well do we support people's wellbeing?"

Leadership and management oversight needs to continue to improve in relation to IPC. The service quality assurance processes must include all aspects of IPC to ensure appropriate action when this is needed. We comment about quality assurance systems and governance processes under "How good is our leadership?".

We concluded that the performance of the service in relation to IPC and Covid-19 was initially unsatisfactory. The service responded to our letters of serious concern issued on 5 and 9 August; practice was assessed as adequate at this inspection.

Areas for improvement

1. Staff should receive further and ongoing infection prevention and control training and observation of their practice to keep people safe and support staff to ensure they are clear about their responsibilities.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their organisational codes.' (HSCS 3.14); and
'I experience high-quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11).

2.
Effective quality assurance systems and processes should be in place in line with current infection prevention and control guidance. These should include an audit of the environment and equipment to ensure this is well maintained, safe and clean.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that:

'I experience high-quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11);
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.' (HSCS 4.19); and
'I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment.' (HSCS 5.22).

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	1 - Unsatisfactory
1.1 People experience compassion, dignity and respect	2 - Weak
1.2 People get the most out of life	1 - Unsatisfactory
1.3 People's health benefits from their care and support	1 - Unsatisfactory

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	1 - Unsatisfactory
3.2 Staff have the right knowledge, competence and development to care for and support people	1 - Unsatisfactory
3.3 Staffing levels are right and staff work well together	2 - Weak

How well is our care and support planned?	2 - Weak
5.1 Assessment and care planning reflects people's outcomes and wishes	2 - Weak

How good is our care and support during the COVID-19 pandemic?	2 - Weak
7.1 People's health and well being are supported and safeguarded during the COVID-19 pandemic	2 - Weak
7.2 Infection control practices support a safe environment for people experiencing care and staff	3 - Adequate

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