Hillgreen Care Limited

2a Oxford Gardens

Inspection report

2A Oxford Gardens
London
N21 2AP

Tel: 02072268989

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24 August 2016
26 August 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

2a Oxford Gardens provides accommodation and personal care for up to three adults with learning difficulties. On the day of the inspection there were two people living at the service.

This unannounced comprehensive inspection took place on 23, 24 and 26 August 2016. At the last focused inspection on 11 December 2015, we found that the service was in continued breach of Regulation 17 and in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to ineffective audit systems which although identified issues around health and safety, did not evidence what actions had been taken to resolve those issues. We also found that there was a lack of staff supervisions and annual appraisals. Requirement notices were issued in relation to these breaches for the provider to make improvements in these areas. As part of this inspection we looked at the breaches that were identified at the last focused inspection to check what improvements had been made.

At the last focused inspection the service was not carrying out supervisions and annual appraisals in accordance with their own policy and procedures. During this inspection we found that all staff were receiving regular supervision and had received an annual appraisal. Care staff that we spoke with also confirmed this.

At the last focused inspection in December 2015, we highlighted to the provider that the freezer that was in use in the garage was in a poor state of repair. The drawers were broken and there was a large build-up of ice. During this inspection we found that the provider had still not addressed this issue. The freezer remained in a poor state with mould evident on the seals of the freezer door. We showed this to the manager during the inspection.

At the time of this inspection there was no registered manager for this location. The provider had arranged for their service manager, who oversees all Hillgreen Care Ltd homes, to take up the manager's position on a temporary basis. 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.

Each person living at the service had a care plan in place. These contained information and some guidance on how people wished to be supported. Risk assessments were available for each person which focused on the activities that each attended and the risks associated with those activities. However, the service did not assess any risks associated with people's health and mental health conditions. As a result there was little or no guidance available to staff on how to reduce or mitigate risks to ensure people were kept safe from harm.

Care plans were not person centred and did not provide any background information about the person, their health and mental health condition and how they should be supported in relation to these. There was little or no information about how the person's mental health or learning disabilities that affected their

behaviour or mood. Where a person was observed to have behaviours that were challenging there was again none or very little information about the triggers that may escalate a person's behaviour and the techniques that care staff could use to de-escalate behaviours that may challenge.

The provider, together with other registered managers from the provider's other locations, completed monthly quality assurance inspections within the home. However, these audits were ineffective and did not highlight any of the issues that we identified as part of our inspection process. Where issues were identified, there was no action plans or systems in place in order to deal with those issues and resolve them.

People told us that they were happy living at 2a Oxford Gardens and we observed them to be well-supported by care staff. We saw positive and friendly interactions between care staff and people. People were treated with dignity and respect.

Care staff that we spoke with demonstrated a good understanding of safeguarding and knew of the different types of abuse that may affect people. Care staff knew whom to report any concerns to and were confident that appropriate action would be taken to protect people from harm.

People were supported to have their medicines safely and on time. There were records of weekly medicine audits and staff had completed training on medicine administration. As part of the training each care staff were observed whilst administering medicine to assess their competency before being allowed to administer medicines alone.

The service followed appropriate recruitment processes to ensure that only staff suitable to work with people were employed. This included obtaining references and completing criminal record checks for each staff recruited. All staff received induction when they first started work with the service followed by regular refresher training in all mandatory topics. However, the service did not provide specialist training relating to identified health and mental health needs of the people using the service.

The manager and care staff had good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The service had followed the correct processes to ensure that where people were deprived of their liberty that this was done lawfully.

During the inspection we looked at the fire extinguishers within the home. We found that the last safety check carried out on the extinguishers was in 2014. We asked the manager about this who told us that checks had been completed in January 2016, however the provider could not evidence this.

At this inspection we found a continued breach of Regulation 17 and further breaches of Regulation 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Warning notices were issued on the provider in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Although some risks to people had been assessed, the service did not assess any of the risks associated with people's health and mental health conditions in order to reduce or mitigate them. Care staff did not have sufficient information or guidelines in order to keep people safe from harm.

Issues relating to health and safety around the home had been identified during the inspection. There was no evidence available to confirm that fire extinguishers had been inspected since 2014.

People were supported to have their medicines safely.

Safe recruitment processes were in place which included background checks, reference verification and criminal record checks.

Is the service effective?

Good

The service was effective. People were supported and enabled to make their own choices and decisions. The registered manager and care staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Care staff received training in all mandatory topics including moving and handling, first aid, medicine administration and safeguarding.

Care staff were supported through supervision and annual appraisal to enable them to carry out their role effectively.

People were supported to eat a healthy diet and were able to choose what they wanted to eat.

People had access to health and care professionals to ensure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring. We observed people to be treated with dignity and respect. Care staff knew the people they supported

well and we saw positive interactions between care staff and the people they supported.

Care staff were able to explain how they supported people to maintain their privacy and dignity.

People were encouraged to be as independent as possible and were supported to make informed decisions about their care and support. We observed people making choices and decisions about the things they wanted to do.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not person centred and did not provide any background information about the person, their health and mental health condition and how they should be supported in relation to these.

People were involved in decisions about their care. Care staff were noted to have a good understanding of people through getting to know them and their changing care needs.

A relative and care professionals that we spoke with knew how to make a complaint. The service had not received any formal complaints. However, the complaints policy was available which outlined the processes the service would follow to deal with any complaints received.

We observed people to have access to a variety of activities throughout the week. People also had access to computer within their home which allowed them to access music and games as well as maintain contact with their family through web based communication programmes.

Is the service well-led?

Requires Improvement

The service was not always well-led. Monthly provider quality assurance inspections were ineffective and did not highlight any of the issues that we identified as part of our inspection process. Where issues were identified, there was no action plans or systems in place in order to deal with those issues and resolve them. This was on an on- going breach which had been identified during the focused inspection in December 2015.

The service currently did not have a registered manager in place.

Care staff were positive about the current manager and felt supported in their role.

2a Oxford Gardens

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 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 23, 24 and 26 August 2016 and was unannounced.

On the 23 and 24 August 2016, the inspection team comprised of two inspectors. On the 24 August 2016 an Inspection Manager also formed part of the inspection team. On the 26 August 2016, one inspector attended the service to complete the inspection.

Before the inspection we reviewed information we had about the provider including notifications and incidents that we had received which had affected the service and the well-being of people using the service. In addition to this we contacted local authority commissioning teams and social workers to obtain feedback about the home and the service people received.

During the visit we spoke with the two people living at 2a Oxford Gardens, the nominated individual, the manager, two deputy managers, three care staff and a visiting social worker. After the inspection we spoke with one relative. We spent time observing care and support in communal areas. We also looked at two care plans and six care staff files. Other documents we looked at included risk assessments relating to the care people received, medicine records, resident and staff meeting minutes, quality audits and health and safety documents.

Requires Improvement

Is the service safe?

Our findings

People living at the service told us that they liked living at 2a Oxford Gardens. Although they were unable to answer direct questions about whether they felt safe or not at the home, people told us, "I like living here" and "I like it here." One relative that we spoke with told us, "She is safe." One social worker whom we met on the first day of the inspection stated, "I am happy, she [name of person] is safe." One health and social care professional, who we had written to for feedback also confirmed when asked if they felt people were safe by stating, "Yes I do." However despite this positive feedback, there were some aspects of the service that were not safe.

Both care plans that we looked at contained a number of risk assessments for a variety of activities that each person took part in. This included risk assessments for café visits, cookery, attending day centres, music sessions, travelling on the bus and visiting the shops. However, there were no risk assessments in place related to people's health and mental health diagnosis. Information was not available on the overall behaviours linked to people's health, learning disability or mental health conditions. For example, both care plans described people as having behaviours that challenge but there were no risk assessments in place which assessed these behaviours, what the triggers were to these behaviours and how staff were to support the person with distraction techniques or de-escalation processes to calm the person down. For one person there was a document named, "Action plan/guidelines on dealing with [name of person] behaviour absconding and personal safety." This document gave information about the person's known behaviours and techniques staff should use to support the person. However, this did not give enough detail about each specific behaviour and how the person may present when, for example, they possibly may self-harm or when they presented with low mood.

One person had been prescribed a high-risk medicine to manage their mental health diagnosis. This medicine is to be administered as part of a specific programme which involves undertaking regular blood tests. A medicine management checklist was in place on the person's care plan which detailed information about the blood tests that had been undertaken and any follow up actions that were required. However, the risks related to this medicine had not been assessed. There are noted significant side effects when taking this medicine which staff need to be aware of as they may have a significant impact on a person's health but these had not been documented. There was no information or guidance to tell staff about the risks associated with this medicine and the actions care staff should take if any side effects were to be experienced by the person.

Staff that we spoke with about the person and the administration of this medicine were aware of the medicine and what it was for. However, they did not have any knowledge of the risks associated with the medicine, the side effects that may present and the actions they should take if those side effects were observed.

On the first day of the inspection we highlighted these concerns to the manager and deputy managers. On the same day the nominated individual devised guidance on the high-risk medicine which included information about the medicine, the risks associated with the medicine, the side effects of the medicine and

the action staff should take. This was to be placed on the person's care plan. However, on the second day of the inspection, care staff had not been provided with this information.

The same person had been prescribed 'as needed'medicines in order to manage their behaviour. 'As needed' medicines are medicines that are prescribed to people and given when necessary. The information available to staff on administering this medicine was not clear. A PRN protocol was in place. The protocol also stated, "You should first try before any medication is given, strategies within my Positive Behaviour Support Plan." Although there was an action plan on dealing with the person's known behaviours within the care plan which noted some strategies to be used, there was no positive behaviour support plan. The action plan was not specific to each behaviour that the person might present with.

For one person we noted that the only reference available in relation to their behaviour was contained within their environmental risk assessment. The assessment stated, "[Person] may display behaviours such as pulling people's hair when upset of wants something." There was no guidance for staff on how to support the person to help calm them down.

Activity risk assessments for the same person stated that, "staff to ensure that they remain vigilant and stay with [name of person] at all times when supporting her in activity sessions." There was no written guidance within the risk assessments guiding staff on how to manage specific identified risks or situations that may arise.

There was lack of consistency in the way that the care planning process was completed for both people living at the service. Where for one person an action plan or guidelines on dealing with the person's known behaviour was available, this was not seen to be available for the second care plan that we looked at.

For the person, where an action plan or guidelines on dealing with the persons know behaviours was available within their care and support plan, this had been written on 26 June 2014 and had been reviewed on 4 January 2016 with no changes. There was a further handwritten note that stated this document had been reviewed on 18 August 2016, However, there was no information on whether any of the strategies had changed or needed updating with regards to supporting the person.

One person had a history of making false allegations about care staff, particularly male staff. Staff were able to explain protocols that the home had put in place to address this issue. However, whilst staff were able to verbally tell us what protocols were in place, these risks had not been assessed adequately. There was no risk assessment in place. There were no protocols for staff to follow.

The manager and the deputy managers were able to explain what people's individual risks were and how they would mitigate those risks, but this information had not been recorded on people's care plans and risk assessments had not been completed. Within 24 hours of the inspection we received a risk assessment which covered the risks associated with a person making false allegations.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a medicines policy which staff had access to. We checked the administration of medicines and found medicines were stored securely. Administration records showed people received their medicines as prescribed. People's medicines were given on time and there were no omissions in recording of administration. Where appropriate, people's medicines were monitored closely through the results of monthly blood tests.

The service had a locked medicines cupboard within the office. Within the cupboard each person had their own shelf which held their own medicines. For one person who had been prescribed controlled medicines, this was kept in a small lockable box within the cupboard. Controlled medicines are medicines that are controlled under the Misuse of Drugs legislation. This means that stricter legal controls apply to controlled medicines to prevent them from being misused, obtained illegally and cause harm.

A medicine administration record (MAR) file was available which contained the MAR for each person under separate sections. Each section contained a photo of the person, 'as and when required' (PRN) medicine protocols and a MAR chart for listing all the medicines that the person had been prescribed. We looked at the MAR charts for both people living at the service. Weekly audits were completed to check stock levels of medicines as well as daily checks of all medicines that were in their original boxes.

Care staff told us and records confirmed that all care staff had received medicine training as well as an observational assessment by a senior manager which assessed care staff competency when administering medicines.

Training records confirmed that care staff had received training in safeguarding people. Care staff that we spoke with confirmed this. We spoke with both of the deputy managers who were very clear on the steps and processes they would follow if abuse was suspected. One deputy manager told us, "I would report any concerns to safeguarding, the police and the local authority and would ensure that the service user was safe." The other deputy manager stated, "Safeguarding is about protecting service users from abuse and harm." Care staff also had a sound understanding of safeguarding and the processes they would follow if abuse was suspected. This also included following the whistleblowing policy where they felt colleagues or senior managers were suspected. One care staff member explained, "Safeguarding is about protecting your service user from abuse. First I have to tell the manager but if the manager did not listen I would tell the local authority, the police or the Care Quality Commission (CQC)." Another care staff told us, "I would follow the safeguarding policy and report my concerns to my manager."

We looked at six care staff files and saw that the service had safe systems in place to manage staff recruitment. The files contained the necessary documentation including two references, proof of identity, criminal record checks and past employment history.

We observed there to be sufficient numbers of staff to support people living in the home and out in the community. Throughout the inspection, there were three care staff members available to support two people during the day. This allocation was so that one person was able to access the community on daily basis as they required two care staff to support them when they were out in the community. During the evening and throughout the night two care staff were allocated to support both people living at the home.

An accident and incident reporting book was in place to record details of any accidents or incidents that had taken place. There had been no noted accidents since 2015.

We looked at maintenance records for the home which included a fire risk assessment, weekly fire alarm tests and a monthly fire drill that had been completed. We also looked at the fire extinguishers around the home and found that the last time they had been inspected was in 2014. We brought this to the attention of the manager who stated that they had been inspected in 2016. However, there the home were unable to produce evidence to confirm this. We also saw records of regular, on-going maintenance checks including gas, electrical, equipment, water temperature and food temperature checks.

At the last focused inspection in December 2015, we reported on the condition of the freezer that was in the

garage and was used to store people's food. We reported that the freezer seals were cracked, drawers were broken and there was a large build-up of ice inside the freezer. The provider assured us that this would be addressed after we had given them our feedback. However, during this inspection we found that the same freezer was still being used. We found that in addition to the broken seals, broken drawers and build-up of ice, the door seals inside the freezer were mouldy. We showed the manager the condition of the freezer on the first day of the inspection.

On the first day of the inspection, with the permission of the people living at 2a Oxford Gardens, we were able to look around their home including visiting their bedrooms. Some draws on the chest of drawers in each room were broken.

Within 48 hours of the inspection, the manager sent us evidence confirming that the fire extinguishers had been inspected and the freezer had been removed and new fridge and freezer had been installed in the kitchen. However, there was no confirmation that the broken chest drawers had been replaced.

Good

Is the service effective?

Our findings

People were supported by care staff that had received appropriate training to do so. The manager, deputy managers and care staff told us and records confirmed that they received regular training and supervision. At the focused inspection carried out in December 2015, the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not following its supervision policy which stated that care staff should receive supervision monthly or six weekly. During this inspection we saw that the manager had put systems in place to ensure that each staff received regular supervisions as per the provider's policy. Staff received monthly supervisions and there was a scheduled plan of supervisions with dates booked for the next four months. We also saw evidence that each staff member who had been working for the provider for more than a year had received an annual appraisal.

Care staff confirmed that they felt supported in their role. One carer told us, "I receive regular supervisions. We talk about my well-being, concerns about service users, safeguarding and training." Another carer explained, "I feel supported. I receive regular supervision. It's not only about if I am doing something wrong but I also get to say what I want." The same carer also stated, "I have had an appraisal and we talked about my development."

Training records were available which listed each staff member, the training they had attended and the date they had completed the course. Each staff member had completed an induction prior to starting work which covered training in mandatory topics such as moving and handling, food hygiene, first aid and safeguarding adults. Records confirmed that care staff received some specialist training in epilepsy, autism and strategies for crisis intervention and prevention but not all staff had received this. The service did not provide any specialist training on people's specific mental health conditions such as training on schizophrenia or bi-polar disorder and how they should be supported.

Care staff confirmed that they received regular training and refresher training where required. One staff member told us, "Over the last month I've done quite a lot of training on social care TV, safeguarding, DoLS etc. We have lots."

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 checked whether the service was working within the principles of the MCA. The service had policies and procedures in relation to the MCA. Care plans acknowledged where people lacked capacity and this was recorded. However, we noted that for one care plan, where the person lacked capacity, they had signed their own care plan consenting to their care which therefore led us to question whether the person was able to understand and comprehend what they were signing. We asked the manager to review this and record appropriately whether the person had the capacity to sign their own care plan.

The manager, deputy managers and care staff had a sound understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One deputy manager explained to us, "Everyone should be deemed to have capacity unless deemed not to and been assessed. If no capacity I would ensure best interests meetings." One care staff when asked what their understanding of the MCA was, told us, "You cannot take away the service users liberty, they have capacity to make a choice and preference about their rights." All staff were aware of the importance of obtaining consent regardless of whether a person lacked capacity or not. One care staff told us, "I would always ask the person so they can make a choice." A deputy manager said, "Listen to them, give them time and let them have their say."

For one person we saw records confirming that a DoLS application had been submitted to the local authority and this had been authorised. For the second person living at the service we noted that the local authority involved had refused a DoLS authorisation that had been submitted at the person's previous address as they believed the person to have capacity. We asked the manager about this because we observed that this person was unable to leave the home of their own free will. A key pad lock was in use and the person who was deemed to have capacity had not been given the key code number as the service did not believe that the person would be safe if allowed to leave the home.

The service had contacted the local authority with a view to obtaining further guidance on whether a new application for a DoLS authorisation should be submitted and we saw an audit trail of this communication. The manager told us that he would follow this up and re-submit an application for authorisation immediately.

People were involved in planning their own menus for the week. Records confirmed that weekly shopping meetings were held, so that people could decide what they wanted to eat. As part of the meeting people and care staff compiled a shopping list and people were supported to go out to do their own shopping. We asked care staff what would happen if a person changed their mind on the day and didn't want to eat what they had originally chosen. Care staff told us that they would offer an alternative choice of what was available within the home. Care staff also told us this rarely happened as people were always happy with the choices that they had already made.

During the inspection, when looking around the home, we noted there to be very little food available in the kitchen cupboards especially in the form of snacks, fruits and drinks. We highlighted this to the manager and care staff. They all confirmed that shopping took place on a weekly basis and food and ingredients had to be purchased within the allocated budget. They also stated that regularly towards then end of the week they did find that they would be running out of food. On the day of the inspection, we were told that shopping had been scheduled for the day after the inspection. Care staff confirmed that if a person expressed a wish for a snack or particular food item that was not available within the home they would be able to purchase this from the local shops. We also saw evidence that people who enjoyed eating particular fruits were supported to go out to buy the fruits they wanted on a weekly basis.

People's weight was monitored on a monthly basis especially as both people were noted to have issues with weight control especially due to certain medicines that they had been prescribed which had side effects, including weight gain. We saw weekly and monthly weight monitoring charts in place which recorded people's weight. If any significant weight loss or gain was noted, this was then referred to the GP for their attention.

One person living at the home followed the faith of Islam and this had been recorded within their care plan. The care plan also stated their choice and wishes about maintaining a halal diet. The entry in the care plan stated, "Staff must make sure that I eat halal food since this is my preference." We checked with the care

staff about whether the meat supplied to the home was halal and they confirmed that it was.

Care plans recorded people's likes and dislikes, choices and preferences. On one care plan it was recorded, "I like to eat and try all sorts of foods. I like to have olives, humus and pitta bread during lunch time. I like to eat boiled eggs for breakfast. I love to eat pasta."

Care plans contained a health action plan for each person living at the home. This document detailed personal information about the person and the support they required in accessing appropriate health and social care support. Records showed that people were supported to attend health and social care appointments and received care and treatment from health and social care professionals such as a GP, chiropodist, optician, dentist, psychiatrists and hairdressers. Where healthcare professionals asked staff to carry out certain actions, we saw that this had been done.

Good

Is the service caring?

Our findings

People told us that they were happy living at 2a Oxford Gardens. One person told us, "I like living here. I am friends with [Person]. I look after [Person]. I love all of you [care staff]." One health care professional told us, "She is comfortable and generally happy." Other health and social care professionals whom we wrote to and asked whether they felt staff were caring stated, "I would say so. They seem to have positive relationships with [Person], who certainly seems to like them, well the ones I have seen her with."

We observed that people were treated with respect and dignity. Care staff had a good understanding of how to maintain people's privacy and dignity. One care staff gave examples of how she spoke with people living at the home. She said, "I knock on the door and say '[name of person] it's me, it's time for your shower, do you mind if I come in'." Another care staff told us, "Dignity is about respecting their choice, preference and privacy and get them whatever they want."

An 'About me' document within the care made reference to how people wished to be supported taking into consideration privacy and dignity. One care plan stated, "If you are supporting me with my personal care please do so in a sensitive respectful way that maintains my dignity. Be patient and don't rush me."

We observed that people were supported to attend activities or if they wanted to go shopping. One person wanted to attend a disco at the end of the week. The person had a leaflet advertising the disco and had begun to make plans with care staff about going to the disco. People were able to choose where they spent their time anywhere around the home which included their own rooms. Throughout the inspection we saw people had freedom of movement around the home. We also observed people holding meaningful conversations with each other. People had developed meaningful relationships with all staff at the home.

We spent some time in the communal areas observing interactions between care staff and people who lived at the service. Care staff were respectful, jovial and caring in the way that they spoke with people. Staff were not rushed and were observed to give one to one attention. People were encouraged to maintain their independence. One person was responsible for certain cleaning tasks around the home and was keen to get them done.

On the morning of the first day of the inspection, we were shown round the home. During this time we observed some positive interaction between the deputy manager and one person living at the home. The person was asking lots of questions. The deputy manager responded in a calm, relaxed and friendly manner. Shortly after, the second person living at the home was sitting in the lounge. The deputy manager asked if she could sit with her and waited for her to respond.

Care plans contained some information about the person. At the front of the care plan there was document called 'About me' which gave information about people, their likes and dislikes and information about their hobbies and interests. This document was pictorial and was easy to understand giving care staff the opportunity to learn things about the person they were caring for.

Care staff knew the people they supported. Even though some of the information was not available within the care plan, care staff had developed a good insight and understanding of the person, their personality and their care needs and requirements. One carer stated, "The care plan helps as well but I have a good understanding of [name of person] and her likes and dislikes."

Each person had a key worker allocated to them. The key worker was responsible for ensuring that the person's care and support needs were met, all documentation was reviewed and updated where required and contact with family and any health and social care professionals involved in relation to the persons care and support needs was maintained. We saw evidence of monthly key worker sessions which were recorded. These were pictorial and asked questions including, "what have you enjoyed this month?", "Any reviews?" and "Comments and suggestions?" Records confirmed that people were involved in these sessions.

The two people living at the home currently did not have an advocacy service available to them. We saw evidence that the manager had made appropriate referrals to access advocacy services for them but accessing such services, especially for the one person who required someone who spoke their language, was proving to be difficult. Social care professionals involved in the care of the people living at the home were aware of this situation.

Care staff understood people's needs with regards to their disabilities, race, sexual orientation, religion and gender and supported them in a caring and respectful way. People's religious beliefs were recorded within their care plan and people were supported to follow their chosen faith which included visiting their chosen place of worship on a regular basis and ensuring religious dietary needs were being met.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care plans for both the people living at the home. We found that some parts of the care plans were person centred and gave detail about what the person liked and disliked, their interests and hobbies and how they wished to be supported with their care and support needs. The 'About me' section was pictorial and included entries such as, "I like to listen to Arabic music and dancing" and "I enjoy attending weekly activities but I may need staff to prompt me to focus while there. Activities that I enjoy: drumming, bowling, music session, arts and crafts and eating out. I enjoy going to the local park and for walks in the community, or just to get some fresh air."

However, we found that person centred care planning was not reflected consistently throughout the care plan. There were sections of the care plan that were task focused and only detailed factual information about the areas in which the person required support. For example, there was no pre-service assessment available on any of the care plans that assessed the needs of the person before their placement at the service was confirmed. We also noted that there was no background information available for each person giving information about the person and their past, their health or mental health diagnosis. The manager was able to locate a copy of the pre-admission assessment for one person on the second day of the inspection.

For one person, who had been diagnosed with a mental health illness and a learning disability, there was no note of this anywhere throughout the care plan apart from on the mental health needs care plan. The care plan only stated, '[Person] has been diagnosed with [name of mental health diagnosis]. To support me with regular visits to my psychiatrist to monitor my mental state'. There was no further information about the diagnosis and what impact this had on the person. There was also no guidance for staff on how to support the person appropriately based on their learning disability or mental health diagnosis.

There were inconsistencies noted on the care plan in relation to capacity and consent to care. One person who had been assessed as lacking capacity had signed their care plan confirming that they consented to the care. Information was also required within the care plan about, 'Who should be involved in making decisions: GP, service manager, keyworker, psychiatrist'. No information had been recorded within the care plan detailing the involvement of any health and social care professional other than on the DoLS assessment form.

For another person who had been assessed to have capacity the care plan had recorded, 'I don't understand all my health needs, people who support me need to agree what is best for me'. There was no further information available within the care plan on how the person was to be supported in relation to their health needs and who would be involved in this process.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence that care plans had been reviewed recently and the next date of review was in six months.

There were not records of people or relatives being involved in the review process, or if not available that any information had been communicated to them about the outcome of the review. We were only able to speak with one relative who did state that the home did communicate with them regularly and that, "Their relative is different to before. She don't get aggressive as she used too."

Records confirmed that for one person a person centred review had taken place with the involvement of a health and social care professional. An action plan had been devised as result. The person whose review it was had been involved in the process. People were also regularly visited by health and social care professionals such as the community nurse and social workers.

Staff were responsive to people's needs. Although there was lack of detail and background history about people in their care plans, care staff were clearly aware of how to meet people's needs and how to manage their behaviours. Care staff had a clear understanding of what person centred care was and how to support people to maintain their independence. One care staff told us, "I help people, I encourage them but I have to supervise. It's about making sure they receive the best care possible." Another care staff told us, "I can see what they can do for themselves, I supervise them with personal care for example. Person centred care is all about the person, what suits them. It's an individual thing."

People were involved in a range of activities not only within the home but out in the community as well. An activity timetable was on display which listed the activities that people were to take part in for the week. This included bowling, music classes, swimming, shopping and attending day centres. Care staff supported people to access these activities.

People were encouraged and supported to maintain relationships with their families and friends. Care staff were aware of how to manage safely contact with families and friends. People were encouraged and supported to keep in contact with family and friends by calling them, writing to them and meeting them at mutually convenient times organised with support from the care staff. One relative that we spoke with told us that they were able to visit more regularly now especially since their relative had moved to the home as this was closer to where they lived.

The home had a clear complaints policy and procedure in place for dealing with and responding to complaints and concerns. The policy described what action the service would take to investigate and respond to complaints and concerns raised. On entering the home there was a notice board which had details and information available to people and visitors on how to complain. There were also forms available called 'I am happy about' and 'I am not happy about'. These were pictorial and accessible to people with learning disabilities. The manager confirmed that they had not received any complaints since the last focused inspection.

Requires Improvement

Is the service well-led?

Our findings

At the last focused inspection the service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach related to the lack of follow up action on health and safety issues that the provider was identifying during their internal auditing process. During this comprehensive inspection we found that the provider continued to be in breach of the same regulation.

We looked at the quality assurance inspections that the provider had carried out during April, May, June and July 2016. These covered accidents and incidents, complaints, safeguarding issues, care plans, staff meetings, staffing, the home environment, health and safety and medicines checks. The quality assurance inspections carried out had not highlighted any of the concerns that we have highlighted during this inspection about people's care plans such as the lack of personal risk assessments and information on high risk medicines, lack of person centred information and no background history or information available about the person living at the home.

During this inspection we had identified that the freezer in the garage was in a poor condition. This had also been identified at the focused inspection in December 2015. The provider had taken no action in order to address this issue. The quality assurance inspections that we looked at made reference to the fridge and freezer within the home and that it was adequately stocked and needed to be moved from the garage into the kitchen but the inspections did not highlight the poor condition of the freezer.

During each of the quality inspection for April, May and June the manager had recorded that the freezer form the garage needed to be moved into the kitchen and the laundry facilities into the garage. This had been highlighted to the provider. However, this action was not fully completed until after our comprehensive inspection.

Where issues were identified these had not been addressed. For example during the provider's quality assurance inspection on 13 June 2016, the deputy manager had highlighted that the fire extinguishers had been checked but the fire inspector had not recorded that date of the check on the extinguishers. A request was made to the provider to ask for the fire inspector to return to record the dates. During this inspection we found that this issue had still not been addressed. Action to the identified issues were addressed following this inspection and at the request of the Care Quality Commission (CQC).

The provider failed to provide the Care Quality Commission (CQC) with any action plan from the focused inspection in December 2015 which they were required to do within 28 days of the report being published.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 9Regulated Activities) Regulations 2014.

The service has been without a registered manager since June 2015. Two managers had been recruited since the last registered manager left the organisation. However, both managers did not continue their employment with the provider. At the time of the inspection, the the service manager, who oversees all

Hillgreen Care Ltd homes, was managing the home on an interim basis.

Throughout the inspection we observed that people knew the manager and other senior managers and were comfortable with communicating their needs to them. One person told us, "I know [name of nominated individual]. There are no problems." One relative that spoke with also confirmed that they knew the manager. The relative told us, "I know the manager, that young fellow, I have met him."

Care staff were positive about the about the current manager. One care staff told us, "We feel much better and comfortable to come to [the manager]. It's good to have a manager what makes us feel comfortable." One deputy manager explained, "Having [the manager] here now I feel a lot more supported. Change has been confusing with different managers." The second deputy manager stated, "[The manager] is here now and we meet once a week. He's around in the morning to see how the day is going. Gives us feedback and talks so that we are all in the loop. Staff are more relaxed."

There were records of regular service user meetings. These took place on a monthly basis. Meetings were led by the people living at the home. Care staff asked people questions about the care and support they received. Minutes of the meetings recorded discussions around activities, what people have done in the last month, visitors to the home, how to complain and safeguarding. The minutes were pictorial so that people living at the home would be able to read and understand the information. Dates for future meetings were on display on the notice boards around the home.

Care staff told us and records confirmed that regular staff meetings were held for all care staff. A care staff meeting had been scheduled for the second day of the inspection and we observed mostly all care staff were in attendance. Agenda items included, people and the support they required, changes in management structure, systems and safeguarding. The current manager had also put in place weekly management and senior staff meetings which were also recorded so that the additional support was available for senior staff members.

We looked at how the home was managing people's personal finances. We found there to be appropriate systems in place which recorded accurately the amount of money people received for their allowance, food shopping and petty cash. Entries were made for incoming funds and for outgoing payments. A recording book was available for people's individual allowances as well as for all other financial transactions. A weekly spreadsheet was then completed and sent to the provider's head office for reconciliation

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that care plans were person centred. Care plans did not provide relevant information about the person, their background history and how those identified needs were to be met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service were at risk because the service did not assess and mitigate individual risks identified as part of the care and support plan.

The enforcement action we took:

We issued a warning notice on 23 September 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not identified significant issues as part of their quality assurance inspections. Where issues were identified there was no evidence of any follow up or actions taken to resolve identified concerns. This may leave people at risk especially in relation to their health, welfare and safety.

The enforcement action we took:

We issued a warning notice on 23 September 2016