Watford And District Mencap Society

Hillside

Inspection report

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21 September 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Hillside is a care home providing personal care and accommodation to seven people. The home is a house with a garden and access to the local town. Most people who were living at Hillside had physical and learning disabilities, including autistic people. The home can support up to eight people.

People's experience of using this service and what we found

Right Support:

People did not consistently receive safe care at the home. New and changing needs were not managed in a safe way for people, which put them at risk. Medicines were poorly administered which meant sometimes people did not get their medicines. Managers and staff did not seek advice when one person was possibly having too much of one of their 'as required' medicine, or when they were being given this medicine for the wrong reasons. People did not have care plans in place to support staff to look after them. Their personal documents were not protected. People's independence was not always encouraged at the home. There was enough staff on duty to support people.

Right Care:

No meaningful or effective work had been completed to check if people were happy with the care provided. No work had been completed to look at people's life goals and aspirations and make plans to try and make these happen. Staff were polite with people, but they did not routinely chat with people as friends and help them follow their interests. Staff did not promote the home as people's own home. Parts of the home looked tired and were uncared for. Some people's bedrooms needed decorating and items replaced, to promote their dignity and make it an enjoyable space to be in.

Right Culture:

The leaders of the home had not created a culture which established a safe and person-centred experience for people to live in. Managers had planned for a new person to move into the home in a way which made them and others feel comfortable about this. But managers had not made plans to ensure there were systems to check they were safe and staff had the knowledge and skills to meet their needs. The provider was not effectively assessing the quality of the care at the home. They were not looking at what people's

experiences were like. The provider had made some improvement plans but these lacked detail and no actions had been taken to improve people's experience of living at the home.

Based on our review of safe and well led the service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 7 August 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, management's response to safeguarding concerns, person-centred care and failures in the leadership of the home at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Hillside

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was completed by one inspector.

Service and service type
Hillside is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hillside is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 13 September 2022 and ended on 29 September 2022. We visited the home on 13 September and 21 September 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We spoke with the local authority to gain their views of the home and we reviewed the records we hold. We used all this information to plan our inspection.

During the inspection
We spoke with four people who lived at the home but some people were unable to talk with us, so we spent lots of time seeing how staff supported people in their day to day lives at the home. We also spoke with three people's relatives.

We spoke with four members of the care staff, the manager, Human Resources manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at a series of documents on each visit to the home. These related to fire safety checks, risk assessments, care plans, and medicine records for five people who lived at the home. We requested further documents such as audits, incident forms, DoLS, MCA assessments, staff personnel checks, and emergency plans to be sent to us electronically.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Staff sometimes forgot to give some people their medicines and did not always sign to say they had given people their medicines. The provider was not regularly and effectively checking staff were competent and able to administer people's medicines safely.
- One person for a period of time was routinely having an as required mood controlling medicine, without any consultation with the GP. Sometimes they were given this medicine when they shouldn't have been. This person was therefore at risk of being over medicated which could have an adverse effect on their mental health.
- New medication administration records were not checked to see if they had people's medicines on them. Staff were confused as to whether some medicines should be given daily or when required. Plans to guide staff when to administer some people's medicines were not being followed by staff. One such plan also needed updating.
- There was poor oversight when people's prescribed creams should be disposed of. Which meant one person was still having a cream applied which should have been discarded.

Assessing risk, safety monitoring and management

- Managers and staff were not managing people's changing and new needs in a safe way. There was no or limited oversight and co-ordination of these needs.
- One person started to have falls. This persons' care was not reviewed with measures put in place to try and keep them safe at the home.
- Managers had not made good plans to ensure a person's new care needs would be met by staff. One person's care plan lacked clear guidance for staff to follow to meet all their needs. Another person had no risk assessment about their changing health needs and the new risks they faced. This put them at risk of experiencing harm.
- Systems and processes had not been created to check these people's health needs were being met safely.
- Other people also did not have risk assessments and care plans about the risks they faced. So, these people were also at risk of their needs not being managed safely.
- Incidents of when a person became distressed or when other people experienced an injury or near misses were not being investigated and managed safely. Even when staff shared an event with a manager which was not managed in a safe way. This was not investigated with actions taken to promote this person's safety.
- There were concerns with fire safety. Fire drills did not take place and evacuation plans were not made to accommodate people's needs and when there are different staffing levels at the home. Staff routinely propped open one fire door to the laundry room rather than kept this closed. The manager arranged a fire

professional to visit to assist with these matters.
● A fire exit door alarm on the first floor was not working. Staff had pagers to alert them of this, but they did not keep the pagers on them. A person's pendant alarm was also not working, staff knew about this, but no action had been taken.
● Cleaning products were left routinely in bathrooms with no risk assessment completed. Managers removed these after our first visit, but staff had returned them back into the bathrooms by our second visit. A person's bedroom floor had been left very wet after cleaning it, staff had not seen this as a potential risk for this person. Cables on people's floors had also not been seen as a potential hazard for some people.
● People's confidential waste was not being managed safely by managers and staff at the home. People's care records and doctor's letters were left in an unsecure chest of drawers with other confidential waste left in shopping bags next to it. This was in a second lounge which two people used.

Preventing and controlling infection
● People's incontinence equipment was stored outside in a container which was open to the elements. It was raining, one package was open and bird faeces were near the packaging.
● The provider had asked staff to follow safe COVID-19 measures when visitors came to the home, such as taking people's temperatures, but staff were not routinely doing this.
● The home was dusty and surfaces were sticky. Staff did not clean frequently touched areas. Pedal bins were broken and food items were not always labelled with open dates. These hygiene issues could make some people ill. Some people had asthma and breathing conditions, people were seen wheezing and coughing. Staff and managers had made no connection to the dustiness of the home, people's breathing issues and taken action about this.

Systems and practices had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's relatives were confident people were safe at the home and with the staff.
● People's relatives were supported to visit their loved ones and there were no restrictions on visiting.

Systems and processes to safeguard people from the risk of abuse
● When potential neglect took place as a result of staff practices managers did not raise safeguarding alerts to the local authority.
● Staff were not all knowledgeable of when they should report a potential concern to managers. Staff did not all know who else they could report concerns to outside of the home and provider.
● Some staff did not know what the potential signs and types of abuse could be. This put people at risk of experiencing abuse and it being unreported to managers.

Appropriate action was not taken when potential neglect or harm occurred. This placed people at potential risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff recruitment checks were not always complete.
● One member of staff did not have a full employment history with gaps clearly explained and documented. New staff had Disclosure and Barring Service (DBS) checks. But when there was a long gap from obtaining a DBS and starting to work at the home, no additional DBS check took place to check nothing of concern had happened in this time frame. These issues could put people at risk.

● There was sufficient staff to meet people's needs. The provider increased staffing when a new person came to live at the home.

Learning lessons when things go wrong
● There was not a culture at the home to consider events, review situations, and learn from these.
● Incidents were not always being recorded and when they were potential lessons learnt, these were not being considered.

● 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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was inadequate day to day management and provider oversight at the home. Emerging risks for people were not being monitored and managed with actions taken to try and reduce the risks for people. When new people came to live at the home effective systems had not been created to check they were safe.
- Managers and the provider had not created robust systems to promote people's safety and to assure themselves people were safe. We found this when people moved to the home, when people's needs changed, with medicine management and fire safety. Even after we had directed managers to our concerns relating to one person, there was still a lack of checks and oversight into some aspects of their care.
- Staff said they did not feel supported to meet people's more complex needs. Staff did not believe they had received enough training and management input to safely meet some people's needs, which were more complex than they were used to dealing with.
- Staff were anxious about being responsible for keeping some people safe. Managers had not responded to this issue in a robust way. This put some people at risk of becoming unwell and being inadvertently harmed.

- People and their relatives had purchased their own bedroom furniture (equipment) because they wanted nicer items of furniture in their bedrooms, and these items were considered to be tired looking and did not match. But the provider had not realised they were legally responsible to provide these. The provider had not created a clear process to support people when they wanted to buy their own furniture.

Continuous learning and improving care; Working in partnership with others

- Managers were not seeking the input of professionals to help them and staff meet some people's needs or when people's needs deteriorated. This included when a person's mental health deteriorated and another person's physical needs changed.
- There was not a culture in the management, provider and staff team to effectively assess what had happened, and what lessons could be learnt. Even when something serious happened, such as when staff forgot to give people their medicines or when staff had not sought advice from a health professional for a person.
- The provider was not checking managers were doing this as part of their assessment of how safe people were, which meant mistakes could be repeated, placing people at harm.

There were key shortfalls with how the provider and managers assessed the quality of the care provided at Hillside. Robust systems had not been established which were used to effectively assess and monitor the

standard of care at the home. This placed people at potential risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The environment of the home was tired and uncared for. Thought was not being given by managers, the provider and staff about how to make the home environment good for people. They were not considering the impact this could have on people's mental health and sense of self-worth. Nor were they advocating in this regard for people who may have a low expectation of what they felt their life should look like.

● The home was dusty, staff left their bags, coats, pagers and disposable gloves about the lounge. Broken furniture and unwanted items were left in the garden in view of two people's bedrooms. One person had a broken set of drawers in their bedroom, with a broken drawer left in the hallway by their room. The managers and staff were not promoting people's spaces as something important and treating it with respect.

● Some people's bedrooms needed decorating and had tired bedding in it. Some people had nice bedrooms but they or their relatives had made this happen. The provider had a development plan dated December 2021. But no plans or actions had been taken to address the issues with the environment. Some work to the home took place in between our visits, but this was prompted due to the inspection, not by the provider's continuous assessment of the home.

● The managers, providers and staff had not completed any work to look at people's goals and ambitions in life and if they were getting enough out of life. There were missed opportunities to promote people's interests and independence at the home. This meant that people were at risk of social isolation and the lack of physical and mental stimulation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Managers and the provider were not assessing people's actual experience of care at the home. They had not created systems to meaningfully engage with people. Most people attended day services but there was no effective review to check they were getting what they needed from these services.

● We found issues with how people's changing health needs and mental health needs were being managed. There were no reviews of these events to see what help they needed and what could be improved for next time. Meaning repeat problems could happen again.

● There was no meaningful regular engagement with people about their experiences of living at the home. People received questionnaires which were not in formats that each person could understand. Nor did they try and stretch people's expectations of what their care should look like and offer new ideas to help people have other options.

People were not being consistently treated in a person-centred way. People were not receiving person centred care that met their needs and reflected their preferences.This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was a complaints process in place. No complaints had been made.

● The provider and manager started to address some of the issues we found when we fed these back to them.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate action was not taken when potential neglect or harm occurred. This placed people at potential risk of harm.

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 9 HSCA RA Regulations 2014 Person-centred care People were not being consistently treated in a person-centred way. This placed people at potential risk of harm in relation to their mental health.

The enforcement action we took:

We issued a warning notice and we will return to check the improvements have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and practices had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm.

The enforcement action we took:

We issued a warning notice and we will return to check the improvements have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were key shortfalls with how the provider and managers assessed the quality of the care provided at Hillside. Robust systems had not been established which were used to effectively assess and monitor the standard of care at the home. This placed people at potential risk of harm.

The enforcement action we took:

We issued a warning notice and we will return to check the improvements have been made.