Hestia Housing and Support

Harwood Road

Inspection report

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20 October 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This focused responsive inspection took place on 18, 19 and 20 October 2017 and was unannounced on the first day. We subsequently advised the provider of our intention to return on the following two days. Harwood Road is registered with the Care Quality Commission to provide care and accommodation for up to 15 men and women with mental health needs, and there was one vacancy at the time of the inspection. The most recent comprehensive inspection of this service was conducted on 4 and 5 May 2016 and the service was rated overall as 'Good'. Effective, Caring, Responsive and Well-led were rated as 'Good' and Safe was rated as 'Requires Improvement'.

The care home provides 13 bedsits, which offer kitchen facilities and en-suite bathrooms. Additionally, there are two single occupancy bedrooms with a shared kitchen and bathroom. Communal areas include a lounge, a separate dining room and activities area, a main kitchen, laundry room, and a small courtyard and garden at the rear of the premises. There are offices which people can use for private meetings. The building comprises four storeys and does not have a passenger lift. The property is owned by a housing association.

This inspection was prompted by two notifications in June 2017, which informed us that two people who used the service had died at the care home on the same day. The provider had originally informed us that the deaths of both people were expected. This was subsequently found to be incorrect when we spoke with the provider, as the deaths of both people were unexpected. In July 2017 we received information from an anonymous source which alleged that the deaths were due to neglect by the provider. It was alleged that some radiators were faulty during very hot weather conditions. We reported these concerns to the local safeguarding team and asked the provider to send us a copy of their own investigation report, and copies of the two Coroner's reports when they were issued. At the time of the inspection we had been informed by the police that they were gathering additional information at the request of the Coroner's Office. Therefore, this inspection did not examine the circumstances of the deaths. However, the information shared with CQC about the deaths of the two people who lived at this care home indicated potential concerns about how the service supported people during very hot weather conditions and the management of risk. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Harwood Road on our website at www.cqc.org.uk.

The service had a registered manager, who had worked for the provider for several years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was no longer working at the service. He had given notice of his resignation and was due to leave the organisation in November 2017. Since the inspection visit to the service, the CQC has received an application for the de-registration of the registered manager and an application from the provider to register the current team leader as the new registered manager.

The provider had addressed a concern identified at the previous inspection, which was a potential risk of a

person not receiving the personal care they needed to meet a health care need. Although the person's support was provided by visiting agency staff, the provider had obtained written guidance for staff and arranged for staff to receive applicable training from a health care professional. This meant that the person's care could be delivered by staff in the event of unforeseen circumstances preventing agency staff from carrying out their visits. However, people's risk assessments were not being updated following a change in their circumstances, for example if they had an accident or hospital admission.

We were sent a copy of the provider's own action plan to improve the standard of safety for people using the service. At the time of the inspection the timescales for completion were not yet due; however, it was difficult to determine how much progress had been made. For example, staff were due to receive training about how to properly switch on and off the radiators. The team leader had not received this training and there was no list to evidence which staff members had been trained.

We found issues of concern in regards to the maintenance of the premises. The service did not have a current electrical installations check by a competent person and there were issues with the lack of cleanliness and equipment to prevent cross- infection in the communal toilets.
Issues about how people were supported with their medicines had arisen as part of the provider's own investigation. We observed safe practices to assist people to comply with their medicine needs.

At the previous inspection we had noted that agency staff were being used to fill staff vacancies and the provider had experienced difficulties with staff recruitment. At this inspection we found that progress had been made to achieve a permanent staff team and the recruitment was satisfactorily undertaken, in order to ensure that people received their care and support from staff with appropriate knowledge and skills.

People who used the service told us they felt supported by staff, although one person told us that the deaths of two people at the service had made them feel anxious. We received some mixed views from health and social care professionals about the quality of care and support people received. The provider had ensured that people were offered support following their bereavements, and this support was also offered to staff.

We were told by the team leader and members of the staff team that there had been a difficult working relationship between two members of the management team which had hampered good communication and effective decision making, but this was now resolved through changes in the management structure at the service. It was not clear when the provider was due to have commenced the actions to improve the safety at the service as the action plan we were shown and the recommendations in the provider's investigation report had different dates.

We found that the service presented as disorganised. The quality assurance reports were of a good quality but there was no clear evidence to demonstrate how the service used the findings and guidance from monitoring visits and other audits. One of the actions from the provider's investigation report was for the staff team to develop mechanisms to engage with people who use the service and obtain their feedback and some work was being undertaken to achieve this.

The provider had not correctly informed us of events at the service which must be reported to the Care Quality Commission (CQC), in accordance with legislation. This information enables us to monitor the service and ensure people's safety.

We have made one recommendation and issued two breaches of regulation in this report. The provider is recommended to seek guidance and advice from a reliable source in regards to its' responsibility to satisfactorily notify the CQC of events at the service. The provider must ensure that people are provided with

a safe and hygienic home and the provider must ensure that the quality assurance system is actively operational in terms of being used to improve the quality of the service people receive.

You can see what actions we have asked the provider to take at the back of this 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.

Risks to people's safety and wellbeing and actions to mitigate these risks were not clearly identified at all times.

There were shortfalls with the provider's systems to ensure that the premises and it's equipment was safely and hygienically maintained.

Appropriate practices were in place to support people with their medicines.

Staffing levels were appropriate and staff were safely recruited.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People told us they felt supported by staff although information from a health care professional and the provider's own monitoring reports showed that some staff did not consistently engage well with people.

The provider's quality assurance system identified clear information about the improvements needed but there was insufficient evidence to demonstrate that changes were implemented.

Improvements were needed to seek people's feedback about the quality of the service and ensure that the Care Quality Commission was properly informed of notifiable events.

Harwood Road

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 and to follow up on concerns raised in relation to the deaths of two people who used the service within a 24 hour period. We inspected the service against two questions we ask about services: Is the service safe? and Is the service well-led?

The inspection was carried out on 18, 19 and 20 October 2017. The first day of the inspection was unannounced and we advised the provider that we planned to return on the second and third days. The inspection team comprised two adult social care inspectors on the first day and one adult social care inspector on the following two days. Prior to the inspection we reviewed the information we held about the service, which included the previous inspection report and statutory notifications received from the provider. These are notifications of significant incidents which the provider is required by law to report to us.

During the inspection we spoke with four people who use the service, one support worker, two senior support and review workers, the team leader and the area manager. We looked at four care and support plans and the accompanying risk assessments. We checked a variety of documents including maintenance records, medicine administration record (MAR) charts, five staff recruitment records, the complaints log, minutes for residents' meetings and staff meetings, quality assurance audits, and health and safety records. We also observed the support and care provided to people in the communal areas and viewed the premises.

Following the inspection we contacted two health and social care professionals with knowledge of using these services and received written responses from both professionals.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we had found that risk management plans were in place to provide staff with guidance to support people in specific circumstances, for example if a person presented behaviours that challenged the service. We had noted that although one person who used the service received support to meet a personal care need from an external agency, there was no written information about how the service would manage potential risks, for example if external staff failed to turn up due to unforeseen circumstances. The absence of this guidance potentially placed the person at risk of not receiving the care and support they needed. The service manager had informed us that they planned to contact the person's relevant healthcare professional for written guidance to include in the care plan and risk management plan. At this inspection we found that suitable measures had been taken to ensure that the provider's own staff had appropriate knowledge and skills to safely meet the person's needs in the event external staff were not available.

Prior to this inspection we asked Hestia Housing and Support to send us a copy of the action plan they had developed following the provider's own investigation into the deaths of two people who used the service. During the inspection, we looked at the action plan with the team leader, who told us that they had been through the document with the area manager. The action plan was divided into five separate categories, which covered the maintenance of the premises, medicines support, health and safety, acquiring feedback from people who use the service and the need to develop a policy for how to safely support people during extreme weather conditions. This policy was due to be reviewed in November 2017 at the provider's Policy Procedure and Best Practice Forum (PPBP), as well as the Death and Dying policy. Following the inspection the provider has informed us that the process is all on track and the draft procedures were now due to be presented at a Performance Directorate meeting in January 2018.

At the time of the inspection we noted that some progress had been attained in order to achieve the stated actions within the action plan. For example, the team leader informed us that the new policy provided guidance about how to ensure people were sufficiently hydrated at night time during hot weather conditions, which included night time 'welfare patrols' by staff to offer people water and fresh fruit. The team leader told us that this action had been discussed with staff during handover meetings and the staff we spoke with during the inspection confirmed that they were aware of the need to do this. However, we found that staff needed additional guidance and training to understand elements of the action plan. For example, there was an action in place to produce a clear local maintenance procedure with information about who to call and what to do out of hours. During the inspection we observed that a senior support and review worker did not follow the required protocols to report a maintenance problem to the housing association and the second senior support and review worker needed to rectify the referral so that it was sent to the correct department.

During the inspection we observed that some fire doors were not closing properly and a door leading from the first floor to the ground floor was sticking, which meant it could not always be opened with the first attempt. A senior member of staff told us that they were aware that some fire doors were not fully closing into the door frames and this had been raised with the housing association for repair. However the doors we

identified for repair were not the same doors as the provider had detected. A new referral to address this issue was sent to the housing association during the inspection.

We noted that a health and safety audit of the premises had been conducted in June 2017. This had been carried out by an external advisor and an overall score of 32 out of 100 had been achieved. This meant that the service had been rated as demonstrating 'poor' compliance with health and safety practices, in accordance with the health and safety advisor's grading system. The audit report provided clear information as to the improvements that needed to be made in order to ensure that people were provided with a consistently safe environment; however the action plan had no identifiable responsible person or completion date. A senior support and review worker informed us about the areas of concern that the provider had addressed; however they stated that most of the identified areas for improvement fell under the responsibility of the housing association. We were told that the provider had sent a copy of the audit with the action plan to the designated individual at the housing association, which had not taken the required actions.

During the inspection we looked at a sample of the health and safety records. The electrical installations were due to have been checked by a competent person in April 2017 but this had not been achieved. Fire equipment had been professionally checked in April 2017 but there was insufficient details recorded to determine which equipment had been checked and passed. A staff member told us they had previously raised this concern with senior management. We viewed the fire risk assessments conducted in May 2017, which had been carried out by an independent fire safety consultant. We asked for evidence that the requirements and recommendations of this assessment had been completed but this was not produced. Therefore we could not be assured that the provider had done all that was possible to protect people from avoidable harm.

We looked at the Personal Emergency Evacuation Plans (PEEPs) for four people who use the service. These are bespoke 'escape plans' for people who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of an emergency. All of these plans showed that people did not need any assistance to evacuate the premises, but there was no recorded information in regards to the name(s) of the staff member(s) who had completed these assessments and the dates.

Parts of the premises were not maintained in a clean and comfortable way. We noted that there was no liquid soap in a communal toilet. This was pointed out to a member of staff and the soap was replenished. Another observation during the inspection demonstrated that there was a lack of appropriate monitoring of the communal toilet facilities. We saw that another toilet had a broken seat, the toilet roll dispenser was broken and there was no liquid soap and paper towels. We discussed this finding with a staff member, who suggested that this toilet might be out of use as parts of the building were being painted. However, there was no sign displayed to advise people that the room should not be entered. A third toilet had a soiled seat. Therefore insufficient steps were taken to prevent and control the spread of infection. Following the inspection the provider informed us that the bathrooms were in the process of being replenished by the cleaner during the inspection and the broken toilet seat had been reported for repair prior to the inspection.

These findings demonstrated that the registered person has failed to provide care and treatment in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had policies in place for safeguarding adults at risk of harm from abuse or neglect, and for whistleblowing. This is when a worker reports suspected wrongdoing at work. The staff we spoke with stated they had received training in relation to safeguarding adults and were able to identify the actions they would

take to protect people who use the service from abuse and harm.

The provider's own investigation following the deaths of two people who used the service had identified issues of concern in regards to how people were supported with their medicines. The investigation report had noted that a member of staff had given advice to a person about taking analgesia. However, they were not qualified to offer clinical advice and should have contacted the NHS 111 telephone service to seek a professional view in order to safely support the person. It had also been noted that people who use the service might have been reluctant to come to the office for their medicines, as the office was also sometimes used for meetings. The team leader told us that new arrangements were in place to support people with their medicines, which ensured that people who use the service had privacy when they came to the office to receive their medicines. We observed this practice during the inspection and saw that people could now confidentially speak with a member of staff if they had any concerns about their medicines, health and/or wellbeing.

We looked at how people were supported to safely take their prescribed medicines. There were systems in place to check that the correct amounts of medicines were delivered and stored appropriately. The team leader carried out checks to ensure that staff signed the medicine administration records and records were kept of any surplus medicines that needed to be returned to the pharmacist. The provider did not have an up to date British National Formulary and the team leader told us that she planned to order one. This is a pharmaceutical reference book which contains information and advice to support staff to safely adhere to instructions from prescribers. We noted that one person did not comply with an aspect of their medicines regime. Staff told us that this had been discussed with the person's GP and clinical advice had been given; however, this was not recorded in the person's care plan.

At the previous inspection we had noted that although people who use the service thought that there were sufficient staff, we had found that there was still a noticeable use of bank staff and regular agency staff. We had observed that this had hindered the provider's ability to offer people the stability and continuity derived from having a permanent and settled staff team. The service manager had told us that a recruitment drive had not been as successful as hoped for and another recruitment drive was due to take place. At this inspection we were informed by the team leader that all posts apart from one had now been filled by permanent staff. The team leader stated that one candidate had been offered a post and was due to start after employment checks had been completed, which would result in a full staff team.

Suitable recruitment practices were followed to make sure new staff were suitable to work in a care service. The recruitment folders demonstrated that appropriate checks were made before new employees commenced working at the service, to make sure that they had the skills and experience to work with people who use the service.

Requires Improvement

Is the service well-led?

Our findings

People who used the service told us they felt supported by the team leader and the staff team. One person talked to us about the impact they felt when two people passed away unexpectedly within one day. They said they missed their two friends and had felt worried about their own safety and mortality. We noted that people had received a visit from a bereavement counselling organisation and staff had spoken with people about their sense of loss.

The comments we received from health and social care professionals were mixed. One health and social care professional told us that they were aware that people who use the service were positive about the quality of the service during their review meetings. They had observed that sometimes staff did not demonstrate that they had got to know people well and did not present as having suitable skills and experience for their roles and responsibilities. The provider's own quality assurance system had observed an incident where a member of staff spoke with a person using the service in an unprofessional manner that lacked empathy. A second health and social care professional informed us that the provider communicated effectively with external professionals and staff were very committed to the welfare of people who use the service. The professional told us that the staff support at night time provided people with a greater sense of security.

The team leader informed us that she had worked at the service for over a year and was planning to apply to the Care Quality Commission (CQC) for registered manager status; this application has now been submitted to CQC. We observed that people who use the service readily approached the team leader during the inspection visit and she was knowledgeable about their needs. We found that the team leader demonstrated an open manner and spoke with us about difficulties she had previously encountered in her role, due to a complicated and problematic working relationship between the former management team at the service. During our discussions with other staff members, they also mentioned the lack of cohesion and harmony at management level and felt the situation had clearly improved now that the team leader was in day to day charge of the service. Staff also told us that there had been a practice in place which they believed prohibited them for calling for maintenance support at the weekends, due to an increased cost. The team leader confirmed that she felt supported by the area manager and demonstrated an understanding of the scale of work that needed to be achieved to improve the quality of the service.

The investigation report by the provider stated that the actions to improve the safety of the service were due to commence in August 2017 although our observations indicated that the action plan was shared with the team leader in the first week of October 2017. The team leader told us that she had been off work with authorised leave for part of September and so had the registered manager, hence this had contributed to the delay.

The team leader told us that they were positive about the improvements that had been achieved since the provider's own investigation visit in July 2017. This included a more robust approach to recording how information was passed from the staff on one shift to the next through the use of new communication sheets. Discussions with the team leader demonstrated that some key changes had been made in recent

months in regards to how the service dealt with environmental faults. We were shown a new template for recording how staff reported faults to the housing association, which included sections to take further action and escalate the concern if the housing association had not responded within an agreed timescale.

The two monitoring visit reports for 2017 that we were shown were thorough and detailed. The monitoring visits were carried out by a team which included a manager from within the organisation and a person who used another service operated by the provider. The monitoring reports covered a wide range of topics, for example the safety and comfort of the environment, risk assessments and care plans, staff interactions and engagement with people who use the service, the food service and medicines administration. Positive findings were noted and the critical observations were explained in a constructive and helpful manner so that the management team and staff could achieve positive changes for the people. However, we did not see the evidence of how these monitoring reports and the separate health and safety audit were being used in order drive necessary improvements.

This demonstrated that the provider's quality assurance system was not being effectively implemented at the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager failed to demonstrate their full understanding of their responsibilities in relation to their registration with the Care Quality Commission (CQC) to inform us without delay about any significant events at the service, as required by legislation. We noted that a safeguarding alert was sent two weeks late and the notifications in regards to the deaths of two people were sent to CQC as expected deaths, which was incorrect. This meant that we could not effectively monitor events at the service to ensure that people's safety and wellbeing were being appropriately maintained.

We recommend that the provider seeks advice and guidance from a reputable source to ensure that notifications are sent in a timely and accurate manner.

The provider's own investigation report had identified that there was a failure to properly listen to and act on feedback from people who use the service, for example if people had concerns about the fixtures and fittings in their bedroom. Residents' meetings were arranged every month but usually only one person chose to attend. The team leader said that the staff team were considering other ways to get people together to share their views. The team leader informed us that there had not been any questionnaires for people and their chosen representatives since August 2016. We asked to look at any records of feedback and/or compliments that the service had received since the previous inspection but this could not be located. We looked at complaints from people who use the service, which dated back to June 2017; however, the team leader was unable to find the complaints from October 2016 until May 2017. The team leader explained that they were not included in various aspects of the daily running of the service at this time. The more recent complaints showed that staff were taking action to resolve concerns for people.

We have observed a noticeable deterioration in the quality of the service since the previous inspection. We were not in a position to check whether the provider had fully achieved the action plan it had developed, as most actions were not due for completion until 31 October 2017. The Care Quality Commission will monitor this through further inspections.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that people were provided with a safe and hygienic home. Regulation 12 (1)(2)(d)(e)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure the effective operation of systems and processes to assess, monitor and improve the quality and safety of the services provided to people, including the quality of people's experience using the service. Regulation 17(1)(2)(a)