Hillgreen Care Limited

Hillgreen Care Ltd - 6 Stoke Newington Common

Inspection report

6 Stoke Newington Common
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 12 and 13 March 2015 and was unannounced. Hillgreen Care Ltd – 6 Stoke Newington Common provides accommodation and personal care to a maximum of six adults with learning disabilities. At the time of the inspection five people were living at the service.

There was a registered manager in post. 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.

A series of improvements had been made to the service since a new management team was set up and the registered manager was motivated to drive forward developments in the quality of the service.

However, we found people were not always protected from potential harm because staff did not have a full

Summary of findings

understanding of the role of the local authority with regard to safeguarding and whistleblowing. Furthermore, staffing numbers were not always sufficient to meet people's individual needs and recruitment processes were not robust because not all references had been validated. The service could not be assured that staff had the skills necessary to meet people's needs because gaps in training were not addressed in a timely manner.

People were at risk because the service did not always manage medicines safely and one person had not received their medicine as prescribed on two separate occasions in March 2015.

The service demonstrated good practice around supporting people who had behaviour that may challenge the service or others. Staff demonstrated a good working knowledge of how to respond to people's behaviour and were guided by health and social care professionals and detailed plans.

People experienced good health outcomes and were referred to health and social care professionals promptly when this was required. People were protected from the risk of poor nutrition and dehydration by good monitoring and staff understanding.

The service had acted lawfully when depriving people of their liberty and staff had a working knowledge of the principles of the Mental Capacity Act 2005. Within this context, risks to people's safety were managed appropriately and people were able to make decisions about their daily care such as bathing preferences and when they got up. People were supported by staff to live as independently as possible. However, the service did not ensure that all people with capacity to make their own decisions received effective support to make informed choices about complex social issues.

There were caring relationships between staff and the people living at the service. People and their relatives were positive about staff attitudes towards them. However, people's dignity was not always maintained as we observed one person's weight being referred to in a derogatory manner by one member of staff.

People's cultural and religious diversity was respected and people who expressed their sexuality were treated with respect. We have made a recommendation about supporting people with regard to relationships and expressing sexuality.

The service demonstrated good practice around providing person-centred care that was responsive to people's needs. People were appropriately involved in their own care planning and care plans were reviewed regularly with care staff involvement to ensure they accurately reflected people's current needs.

People were protected from the risk of social isolation during the day because there were a range of day time activities available. However, evening activities were lacking; therefore people were not supported to maintain a full social life.

People felt they could raise issues with staff and there were regular keyworker sessions and residents' meetings where people could feedback about the service. However, there was not a system to effectively track concerns and relatives felt issues they raised were not always dealt with to their satisfaction.

There was an open culture at the service. People and their relative's spoke highly of the registered manager and staff felt they could approach him with any concerns. Internal communication systems were effective and staff were aware of their roles and what was expected of them.

However, the service was not always organised in a way that promoted safe care through effective quality monitoring and spot checks of staff were not undertaken. Statutory notifications were not always submitted where necessary. We have made a recommendation about implementing a statutory notification system.

We found breaches of four regulations relating to safe care and treatment, statutory notifications, dignity and respect and good governance. The action we have asked the provider to take can be found at the back of this report.

Summary of findings

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. People were at risk owing to poor medicine management.

Recruitment processes were not robust.

People were positively supported when they portrayed behaviour which may challenge others.

Is the service effective?

Requires improvement

The service was often effective but not always consistent in its approach. The service did not have an effective system to identify gaps in staff knowledge and provide training in a timely manner.

People were supported to make choices about their daily routine by staff who had a basic understanding of the principles contained in the Mental Capacity Act 2005.

People were protected from the risk of poor nutrition and dehydration.

Is the service caring?

Requires improvement

Aspects of the service were not caring. People's dignity was not always maintained and, at times, staff were focussed on the task at hand rather than the people they support.

Where applicable, people's consent to care was obtained and they were involved in their care planning. However, not all had been done to communicate fully with people who could not express themselves verbally.

Staff were often caring and developed compassionate relationships with the people they cared for. People's diversity was respected.

Is the service responsive?

Requires improvement

The service was not always responsive. People were not fully supported to maintain social interactions with their peers.

Concerns raised by relatives were not always dealt with to their satisfaction.

Staff had worked hard to provide personalised care that was responsive to people's changing needs.

Is the service well-led?

Requires improvement

The service was often well-led but not consistent in its approach. The registered manager was well liked and had made successful improvements to the service.

Quality monitoring systems were not as robust as possible and statutory notifications were not always submitted where necessary.

Hillgreen Care Ltd - 6 Stoke Newington Common

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.

The inspection took place on 12 and 13 March and was unannounced. The inspection team consisted of an inspection manager and an inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the local learning disability team. We also reviewed the information held about the service and the statutory notifications received over the past 12 months.

We used a number of different methods to help us understand the experiences of people supported by the service. We spoke with the registered manager, the service manager and three care workers. We talked to two people using the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records in detail, three staff files, as well as records relating to the management of the service.

Following the inspection we spoke with three people's relatives to get their views on the service.

Requires improvement

Is the service safe?

Our findings

People reported they felt safe at the service. One person said, "I'm always safe". Three relatives we spoke with stated that it was safe and their family member was "happy". Despite these positive comments we found that the provider's approach to protecting people from avoidable harm and potential abuse was inconsistent.

People were not kept safe from all hazards. We observed that a used sharps bin was kept in the unlocked basement. We immediately raised this as a concern with the registered manager who arranged for the door to be locked.

People were at risk because the service did not consistently follow safe practice around the storage, administration and disposal of medicines. For example, we found that during March 2015 one person had not received their medicines as prescribed on two occasions. Furthermore, people's mental health was at risk because protocols for the administration of 'when required' medicines were inadequate. Protocols give guidance to staff about when to offer a specific medicine to a person. In one instance, we found that one protocol stipulated two different timeframes for administration of the medicine. We noted one medicine that had been set aside to be collected by the pharmacy for disposal before March had not been returned and was still in a locked cupboard.

The above issues relate to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we raised these concerns with the registered manager, he immediately contacted the individual's psychiatrist to confirm the correct action to be taken and complied with the responses received. The registered manager then changed the medicines system and communicated this with staff. This demonstrated a commitment to learn from incidents.

Staff were able to identify the different types of abuse and stated that they would report any instances of abuse to the registered manager. However, not all staff had received safeguarding training. One staff member was not aware of the role of the local authority in such situations. Staff were aware that they could whistleblow and inform senior managers at the care home and the Care Quality Commission of suspected abuse. The safeguarding and whistleblowing policies did not provide contact details for the appropriate local authority safeguarding teams. However, the registered manager was informing the relevant outside agencies of incidents and had a very good working relationship with the local authority community learning disability team.

People were protected from harm by effective risk assessments. A wide-range of risks were identified and managed and assessments were signed by people using the service. However, one person was subject to a generic risk assessment that did not apply to their situation. This person was able to go safely into the community by themselves but their risk assessment stated they needed to be supported by a member of staff at all times.

Staff we spoke with and observed gave people information about daily risks and actively supported them in their choices so they had as much control and autonomy as possible in day-to-day life. Risk assessments were updated following incidents to ensure they accurately guided staff about managing potential risks.

It was noted that personal emergency evacuation plans were available and staff were able to explain how they would support people to evacuate safely in line with this guidance. In addition, internal weekly fire tests and monthly fire drills were carried out.

People were positively supported when they portrayed behaviour which may challenge others. Staff had been trained in an accredited method used to defuse situations and to physically intervene as a last resort. Positive behavioural support plans included information about triggers and guidance for staff about how to respond and manage risks. Staff we spoke with understood the method well and were able to explain how they would put it into practice. We observed staff using the de-escalation techniques outlined in the care plans. However, one staff member had not received the training.

People who had behaviour which challenged were referred for professional assessment at the earliest opportunity. Records showed that a multi-disciplinary team meeting had been called as soon as someone's behaviour began to challenge the service and the team were working together

Requires improvement

Is the service safe?

to put the recommendations of the behavioural consultant into practice. However, we noted that incident records did not always contain enough specific information to assist with monitoring and lesson learning.

People were sometimes restricted from doing what they wanted owing to insufficient numbers of staff. For example, on two shifts one person had worked an eight hour day shift and then worked the subsequent waking night shift. The rotas we reviewed showed there was always a minimum of two staff on duty, but at the weekends this was frequently the maximum number. This limited the activities that could be offered to people. One relative stated they did not think they had adequate staffing levels to provide the one-to-one support to which their relative was entitled.

The recruitment system was not robust because two references for staff members had not been verified to ensure their authenticity and gaps in employment history had not been explored. Each of the four staff files we reviewed contained information about relevant qualifications, an application form, proof of their right to work in the UK and criminal record checks.

We recommend that the provider reviews their staff recruitment practice.

Requires improvement

Is the service effective?

Our findings

The service could not be assured that people's needs were being met consistently by staff who had the right knowledge and skills for the role because the provider did not have an effective system for addressing gaps in staff training in a timely manner. The training matrix showed that some staff had not completed all their health and safety training, nor had they completed other short courses which would help them to meet the needs of people who used the service.

People were involved in managing their own health care and experienced positive health outcomes. For example, one person talked about their diabetes and showed an understanding of how it could affect their health and how they should manage it. They said that staff had told them about this. Health action plans were reviewed regularly and were in an easy-read format. The care plans we reviewed contained detailed information about people's health needs such as diabetes. The service engaged with health services appropriately and there was evidence staff supported people to attend healthcare appointments. Staff monitored health needs on an ongoing basis and acted on signs of deterioration. A member of staff stated: "In the past [a person] has pain in [their] stomach or a headache...We have to inform the manager or senior and they call the GP." Timely referrals to specialists, such as psychiatrists, were made and multi-disciplinary team meetings were held on a monthly basis to assess people's ongoing health and social care needs.

People had been legally deprived of their liberty and were protected by safeguards to ensure it was in their best interests. For example, we noted the front door and kitchen were kept locked by staff. The provider had appropriately submitted Deprivation of Liberty Safeguards (DoLS) applications for all people which had been approved by the relevant local authority. Within this context, people were supported to live their lives in the way they chose. Staff had an understanding of the principles in the Mental Capacity Act 2005 (MCA) and sought people's consent when providing personal care. It was observed that staff positively managed behaviour that may challenge others.

People with complex needs were protected by staff from the risk of poor nutrition and dehydration. For example, we observed 'soft' food being provided to someone who experienced difficulties swallowing. Staff we spoke with understood the specific dietary needs of the people they cared for and were supported by a healthy diet plan in care records. The staff encouraged someone who was underweight to eat snacks throughout the day and gave small manageable portions so that the person was not put off eating by larger portions.

Relatives stated that their family members did not complain about being hungry. There were snacks in the Kitchen including, fruit, tea, coffee, soft drinks, cereals and yoghurts. The kitchen was locked in line with each person's DoLS authorisation and we observed staff letting people in and responding to requests for food and drink promptly. A staff member told us they gave people a choice of meals and there were "a lot of fruits and fresh food always." There was monthly weight monitoring for those whose weight was of concern and evidence of referrals to a dietitian when appropriate.

Staff were well supported to carry out their role and responsibilities. Records confirmed that staff received regular supervision sessions and yearly appraisals to discuss their work. Staff had completed an induction which consisted of a period of shadowing more experienced colleagues before working independently. We reviewed minutes of effective staff meetings that were held regularly and provided updates about people's care.

We recommend that the provider finds out more about training for staff, based on current best practice, from a reputable source in relation to the specialist needs of people living at the service.

Requires improvement

Is the service caring?

Our findings

People and their relatives were positive about the attitude of the staff team and their treatment of people living at the service. One person said, "They help with everything…they're nice people." A relative stated, "They are rather caring. [My relative] likes them. They are gentle."

Despite people's positive comments we found some aspects the care provider were not always caring. One person with non-verbal communication skills was not supported by a robust communication system and there were some inconsistencies in staff knowledge about their communication needs. One staff member used signs to understand what the person wanted to do, "If [they do not] want to do something [they] will say no by signing [their] hand over [their] neck... We used to use pictures… [They will] do breaststroke sign for swimming." Other staff were unsure of communication techniques. Other methods such as pictorial aids were not used and the registered manager identified that a referral to a speech and language therapist was required in order for the person to express themselves fully in relation to more complex decisions and interests. The service had not done everything reasonably possible to communicate with this person to ensure staff understood them and enabled them to make meaningful choices.

People's dignity was not always maintained. One staff member spoke inappropriately about someone while they were present in the lounge referring to their weight in a derogatory manner. We discussed this with the registered manager who said they would address this immediately with the staff member in question. We saw evidence that the inappropriate use of language had recently been discussed within the team. During lunch, we observed that, although there were some conversations between people and the staff, one member of staff infantilised someone and staff were primarily focussed on tasks.

The above issues relate to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service encouraged staff to deliver person-centred care. Care plans contained information about people's preferences and staff had built up positive caring relationships and had a good understanding of people's personalities and their likes and dislikes. A member of staff spoke warmly, "[A person] is good with computers, very good at maths. We sit down and watch the football together. [They] like Chelsea and I like Arsenal!" We observed some positive interactions between staff and people using the service and at times we saw people chatting with each other. It was clear that people knew the registered manager well and responded positively to him.

People were encouraged to maintain and develop independent living skills within the context of their needs and ability. We observed one person taking washing to the laundry. Another person told us they cleaned their room and did their own shopping. Staff had a proactive attitude to involving people in their care, "[If they are able to do it] you ask them to help. [One person] can hoover and make [their] bed. You oversee and involve them." One relative thought their family member's independence was well managed, "They bought [my relative] a new mobile and taught [them] how to use it. [They go] out [by themselves] during the day." People were able to make choices about what they did such as going out or playing games.

People's cultural and religious diversity was respected. One person told us about their heritage and was proud of this. It was evident that staff had supported them to maintain their cultural identity. Their relative stated they went out into the local community which met a lot of their cultural needs. People's religions were recorded in their care plans and they were supported to attend places of worship when they expressed an interest in doing so.

People who expressed their sexuality were treated with dignity and respect. For example, at times, staff talked to them about their feelings. However, the registered manager identified there were ways the service could improve to support people in this area and there were plans to develop the service around this.

We recommend that the service seek advice and guidance from professionals and reputable sources about supporting people with regard to their relationships and sexuality.

Requires improvement

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Their needs, choices and preferences were identified and communicated to staff in care plans. The registered manager stated, "When I make an assessment of a client to come here, I look at whether I can care for them or not, for whatever reason, including resources and whether they would get on with the other residents." These effective pre-admission assessments formed the basis of the care plans. People's preferences, such as types of toiletries and bathing options, were included and they were written from the perspective of people using the service. A member of staff from the local authority learning disability team stated the staff "really wrap the service around the service users".

People were involved in their care planning and consent to care was obtained where possible. Plans were discussed with people who used the service and their views were recorded. Pictures and symbols were used in relation to the information about themselves and people had signed their agreement to care plans.

There was a robust review system to ensure care plans reflected people's needs as they changed. Staff reported that they were involved in this process and had the opportunity to feed into discussions about people's care. For example, a care plan had been updated to cover the support someone needed when they displayed a new behaviour. The local authority was also involved in assessing how a person's needs could be met for example, the number of hours someone went out each day.

People were protected from the risk of loneliness during the day. The service supported people to undertake activities during the day. In the last month, one person had been to the Natural History museum, Science museum and been bowling. A relative said since the current registered manager had been in post, "There's not so much sitting around…they tend to take them out to the park, they have music." Staff encouraged people to be as independent as possible during activities.

People were supported to maintain their hobbies and interests. For example, one person's care plan stated they liked football and staff took this person to the park to play football in the afternoon. One person liked listening to music from their own culture and was supported to do so. They confirmed they listened to this in their room.

People were also supported to undertake more long-term activities. For example, staff were in the process of arranging for one person to help at a local restaurant once a week because they had expressed a wish to have a job. Another had been supported to go on holiday with the registered manager.

People were supported to maintain meaningful contact with their families. For example, staff looked at one person's family photographs with them and supported them speak to their relatives on the phone.

However, people were not always supported to fully integrate with society. People were not always supported to engage in social opportunities during the evening similar to those enjoyed by many people of their age. One relative expressed a wish that their family member be supported to do more activities with their peers. The relative stated this concern had not been dealt with to their satisfaction by "head office". The service had not developed a written record of this complaint to monitor how they dealt with it. Concerns from relatives were not centrally recorded by the service to monitor how they were dealt with.

People's feedback was obtained and acted upon in a timely manner. People felt that they could raise concerns with staff. One person said in the event of a problem they would "tell the manager or my keyworker". The complaints procedure was in an easy read format, though this had not been displayed around the home. People were able to feedback about their care at an individual and group level. During weekly keyworker sessions people discussed decisions that affected them, such as shaving preferences. Group, house meetings were held on a monthly basis. Staff took any feedback seriously and acted on concerns raised. There was a suggestion box on the ground floor for residents and visitors to use for ideas to improve the service.

Requires improvement

Is the service well-led?

Our findings

Everyone we talked with spoke highly of the registered manager. One person said, "The manager is good". A local authority representative described the registered manager as competent and was impressed with the work put in to ensure people's experience of care was positive. It was evident the service had undergone improvements since the current registered manager had been in post. Relatives described him as "proactive rather than reactive" and another had noticed their relative's wellbeing had improved since the new management team took over.

The registered manager emphasised the importance of delivering care tailored to the individual. Staff knew people well and care plans contained detailed information about people, their needs and behaviour. Four members of staff had received training in person-centred care and care staff were involved in care planning. The registered manager ensured safe care and a multi-agency response by maintaining good working relationships with other health and social care professionals, in particular, the local authority community learning disability team and behavioural specialists. However, the obligation to inform outside agencies of incidents was not always discharged. For example, there were several instances where the service had not submitted statutory notifications of significant events to the Care Quality Commission. The registered manager was unable to demonstrate a full understanding of when notifications should be made.

This was a breach of Regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

The service was not always organised in a way that promoted safe care through effective quality monitoring. The manager's oversight of the service stemmed from working some shifts and he evidently knew people well. Action plans to improve the service were formulated based on quality monitoring visits by regional managers. For example, we could see information missing from care plans had been identified and rectified. The management team were aware of some, but not all, of the areas for improvement we identified, however, more could be done to identify areas for improvements. Spot checks of staff and surveys to gather the views of relatives, people living at the service and professionals were not undertaken and the registered manager recognised these would improve service monitoring. The recording systems used to learn from incidents and to manage the risk of the events occurring again were not detailed enough to ensure the service could respond appropriately in the future.

The above issues relate to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from harm because there was an open culture at the service. Staff had a good understanding about their roles and responsibilities and felt supported by the registered manager and senior care worker. They reported they felt able to approach them with any concerns, "The managers are very helpful. They listen to us. Everybody gets along with [the registered manager]." We observed staff being motivated and praised by the registered manager who stated the team culture was based on openness, trust and honesty.

Internal communication systems for staff to contribute their views about the service and to provide mutual support were effective. Information was shared between team members at daily meetings. We observed the team being informed of an external problem with prescriptions and what they needed to do to support people whilst the issue was sorted out. At each meeting a team member was selected to recap the information from the previous meeting to check understanding. Regular supervisions and yearly appraisals meant staff had a space to share their views and reflect on their practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 People were at risk because medicines were not managed properly or safely. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The service did not ensure that the service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established to assess, monitor and improve the quality and safety of the services provided or to seek and act of feedback from relevant persons and other persons on the services provided for the purposes of continually evaluating and improving such services. Regulation 17(1), (2)(a) and (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not submit statutory notifications of significant events as required.