Hillgreen Care Limited

Hillgreen Care Ltd - 6 Stoke Newington Common

Inspection report

6 Stoke Newington Common
London
N16 7ET

Tel: 02088060303
Website: www.hillgreen.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 31 July, 2 August and 3 August 2017 and was unannounced. The provider knew we would be returning for the subsequent days. Hillgreen Care Ltd - 6 Stoke Newington Common is a residential home which provides care and support to a maximum of six people with learning disabilities, some of whom may also have mental health conditions. At the time of the inspection there were two people living at the service. Only one of these people was currently residing at the service at the time of the inspection.

There was not a registered manager at the service at the time of our inspection. 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.

People were not always protected from risks to their wellbeing because there was not a robust staff recruitment process in place. Criminal record checks and references were not always obtained prior to a staff member starting work at the service. People were not always protected from risk of harm because environmental checks and risk assessments were not always completed or up to date.

There was a negative culture at the service and staff morale was low. There was poor communication between the senior management team and the staff at the service. The service was not organised in a way that always promoted safe care through effective quality monitoring. There was inconsistent management at the service as the manager had resigned two weeks before the inspection and the deputy manager was acting as the service manager. As a result, staff meetings were not being routinely held and the acting manager was not aware of the statutory obligation to report all issues that affected the service to the Care Quality Commission.

People were supported to eat and drink enough but people were not protected from the spread of infection because the service was providing people with out of date food to eat. .

People were protected from risks resulting from their specific health and care needs because effective risk assessments were in place to guide staff about how to manage specific risks. People were supported to obtain care and treatment from health care professionals and medicines were managed adequately.

People felt safe and were protected from the risk of potential abuse. Staff were knowledgeable about safeguarding processes and knew what to do if they had concerns about the service. Staff were observed to be caring and promoted people's independence and dignity.

There were enough staff to meet people's needs. People were involved in planning their care and care records included information about people's likes and dislikes and promoting their independence.

Staff were trained to carry out their roles and newly appointed staff were supported in their role by an induction period.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found five breaches of the Regulations around fit and proper persons employed, safe care and treatment, complaints, statutory notifications and good governance. We made one recommendation in relation to meeting nutritional and hydration needs. 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?

Inadequate

Aspects of the service were not safe. The recruitment procedure was not effective in order for the provider to be assured that staff were suitable to work in the caring profession.

Environmental risks to people's wellbeing were not well managed.

Risks to people's health and wellbeing were identified and detailed plans about how to manage the risk.

People felt safe and were protected from the risk of potential abuse.

Medicines were managed appropriately.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

Aspects of the service were not effective. People were served out of date food.

Staff received training and support relevant to their roles.

The service was committed to working in line with the Mental Capacity Act (2005).

Staff supported people to receive care from health and social care professionals.

Is the service caring?

Good

The service was caring. Staff had developed compassionate relationships with people.

People were supported to be independent and were treated with dignity and respect.

Care staff demonstrated they knew people well.

People were involved in planning their own care.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive. People, their relatives and professionals were not always given the opportunity to feedback about the service.

Care staff provided care tailored to the individual.

Is the service well-led?

Inadequate

The service was not always well led. There was not a registered manager in place. Monitoring systems were limited and not up to date.

The service had negative culture and staff morale was low.

The service did not routinely notify the Care Quality Commission about issues that affected the service.

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 31 July, 2 August and 3 August 2017 and was unannounced. The provider knew we would be returning for the subsequent days. The inspection was conducted by one inspector.

Before the inspection we reviewed the information we held about the service and statutory notifications received about significant events that affected the service as is required by law.

During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We spoke with one person using the service, the acting deputy manager, the service manager and two members of care staff. We made observations at the service. We looked at two people's care records, and three staff files, as well as records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were at risk of harm because the recruitment process was unsafe. The provider could not be assured that people were supported by staff who were suitable for work in the caring profession. One staff file we reviewed demonstrated that a staff member had commenced work before the provider had obtained the relevant criminal record check via the Disclosure and Baring Service (DBS) had been obtained. The DBS is a check to see if prospective staff have any criminal convictions or are on any list that bars them from working with vulnerable adults. The provider had requested a reference from two of the person's previous employers. One of the references for this person was returned blank and no explanation had been recorded by the provider. The criminal record checks demonstrated that this person was unsuitable for working in the caring profession and the provider had not taken adequate action by extending their work-probation. The provider therefore, could not be assured that fit and proper persons were employed because they did not have a system to ensure criminal record checks were available in relation to each staff member when they commenced employment. This had put people at risk of harm or abuse from those unsuited to the caring profession. The acting manager was not aware of these circumstances so could not monitor the situation. The issues above relate to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from risks to their health and wellbeing because risks associated with the environment were not always assessed and up to date. The provider had not facilitated a fire assessment or a legionella assessment by external experts and there was no documentation held at the service in relation to such assessments. The fire extinguishers were overdue for external review to ensure they were in good working order. This left people living at the service at risk of harm related to a contaminated water supply or in the event of a fire due to unsuitable equipment or premises as the provider had not made themselves aware of any potential faults. The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from risks resulting from their specific health and care needs because staff were aware of the risks people faced and how to mitigate them. We reviewed a wide range of comprehensive risk assessments in people's care files such as those relating to nutrition, falls and going out into the community. These assessments had been tailored for each person and the associated risk assessments and care plans provided staff with clear and detailed guidance and direction on how the person should be supported. Staff were aware of the specific risks people faced and assessments were updated regularly. For example care plans for supporting people with diabetes guided staff about how to support the person if their blood sugar levels were too high or low and staff were aware of the guidance and how to support the person in this area. There were clear risk assessments to support people whose behaviour may challenge the service. Triggers for behaviour were identified with clear examples of how to support people at different stages of concern.

People were protected from the risk of potential abuse. People told us they felt safe and were supported by care staff who knew who to contact if they had any concerns. One person said, "It is so safe". Staff had received training in safeguarding adults from abuse and had a good understanding of what may constitute abuse and how to identify it. Staff were aware of their duty to report any concerns to their manager. We

noted that the provider had appropriately handled one safeguarding incident since the last inspection and had reported it to the local safeguarding team and the Care Quality Commission (CQC) as required.

People were protected from the risk of poor practice because staff were supported to escalate concerns if needed. Staff were aware they could contact the local authority safeguarding team, CQC and the police if they felt the matter was not dealt with appropriately internally but told us this had not been necessary since our last inspection. Staff were guided by an appropriate safeguarding policy and the acting manager discussed it with staff members at each supervision. We noted that incidents at the service had been recorded appropriately and plans had been put in place to prevent them from reoccurring.

There were enough staff to meet people's needs. A person told us, "Yeah, there are enough staff around." There were two members of staff on duty during the inspection supporting the one person who was residing at the home and the rota we reviewed demonstrated that these levels were consistently provided and staff corroborated this. Staff told us they were able to contact the acting manager outside of normal working hours by telephone.

Medicines were managed adequately; they were ordered, stored in a locked cupboard and returned safely. A person told us they were always supported to take their medicines and there hadn't been any problems. Care staff had received relevant training to safely administer medicines and had accurately completed the medicine administration records we reviewed, including reasons why medicines had not been given. The amount of medicine at the service corroborated with them amount that had been administered. Clear protocols for giving medicines on an as required basis had been drafted to guide care staff.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 26 January and 3 February 2016 we found a breach of the regulations in relation to training. At this inspection we found that the provider had made the necessary improvements to support staff. Staff were trained to meet people's care and support needs. The provider kept a training log which showed staff were equipped with the relevant knowledge to carry out their roles. We noted the provider had carried out staff requests for training about how to support people with bi-polar disorder. New staff members underwent an induction including mandatory training and shadowed more experienced staff members to better understand how to support people. Staff told us the training they received was relevant to their role. Staff members had regular supervision sessions which provided a good forum to discuss training areas and to highlight important aspects of staff roles. Staff told us these were useful and helped them carry out their work. Records of supervisions and annual appraisals were up to date and covered a broad range of topics.

People were supported to eat and drink enough, however a person had been given ham and milk that was out of date by five days but being stored in the fridge. The acting manager agreed the food was out of date and disposed of it immediately. Despite this concern, the person we spoke with told us, "Yeah, it's very good food." We observed people being given choices about what they ate and joined in with making the food. We noted that the person was supported in line with their preferences and dietary requirements which were recorded in their care plan. Nutrition support plans were clear and included likes and dislikes and what to say to encourage people to eat a healthy diet. Monthly weight charts were completed where appropriate.

We recommend that the provider seek advice and guidance from reputable sources about the safe storage and disposal of food stuffs.

People's rights were protected as staff understood their responsibilities under the Mental Capacity Act 2005 (MCA). The 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. 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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were supported to live their lives in the way they chose. We observed staff supporting people to make their own choices about their care. The service had involved family members and social care professionals in decisions about their care as appropriate. Staff were aware of how the MCA and DoLS affected their work and complied with conditions appropriately, one member of staff told us, "[Person] can make their own decisions." Another said, "I give them the reasons behind the task but I don't force them."

People were supported to maintain their optimum health. A person told us, "I go to the doctors and dentist." There was evidence in people's care records that the provider worked collaboratively with healthcare

professionals such as district nurses, psychiatrists, GPs and opticians. Staff were aware of situations that may impact adversely on people's health, including mental health and gave examples of when they had made requests that other healthcare professionals attend to help the person urgently.

Good

Is the service caring?

Our findings

Staff developed caring relationships with people using the service. One person said, "They are good. I talk to them." Staff we spoke with had created a positive relationship with the people they supported and all spoke kindly about them. One member of staff said, "I treat her like my big sister. It's lovely, we have empathy." We observed that staff members were polite and respectful to people throughout the inspection and communicated with people with warmth. We noted that the person living at the service appeared happy and relaxed during the inspection. Care records emphasised the importance of the relationship and stipulated for key workers to be 'relaxed and fun at all times'. Key workers were matched to the people living at the service and people were able to go to them to discuss things that were important to them. People had lived at the service for a long time and were supported by an adequately consistent staff team who knew people well.

Staff supported people to express their views and involved them in day to day decisions about their daily lives and support. We observed that people were given choices about different aspects of their care. Staff gave examples of how they communicate with people including making sure people were settled first so that they may fully express themselves. Care plans provided clear guidance for staff about how to support people to share their views and we observed care staff putting this into practice. Care plans were in pictorial format so they could be more accessible to service users during discussions about their care.

People's privacy and dignity was promoted. Staff took action to ensure people's privacy, "I'll knock on the door before I go in. I'll tell [person] what I'll do if it's ok by them." For one person, privacy was very important and we observed that this was respected by staff in line with detailed guidance in their care records.

People's independence was championed. A member of care staff told us, "We want them to be as independent as they can be." Staff were aware of people's ability to do certain tasks and how important this was to them such as washing and dressing themselves. This had a positive impact on the person's wellbeing and their self-esteem.

People's diversity was promoted and a person using the service told us they felt respected. A religious and cultural support plan had been completed for each person and we saw staff following these such as at meal times. We noted that religious leaders visited people at the service and people were supported to worship in a way they chose.

Requires Improvement

Is the service responsive?

Our findings

The provider did not do everything reasonable in order to give opportunities for people to provide feedback about the service. Service user meetings, a forum for people to discuss what they wanted from the provider and raise any potential concerns, had been stopped because of changes at the service. A suggestion box was not present at the home meaning visitors could not leave anonymous suggestions. Formal feedback from professionals or relatives was not sought through methods such as questionnaires or meetings. However, a person we spoke with said they felt confident about telling staff if something was wrong and but they had not needed to do so. There were no records of official complaints since our last inspection and the acting manager confirmed that none had been made. We recommend that the provider seek guidance from reputable sources about seeking feedback from people using the service, their family and health and social care professionals.

People's individual needs were appropriately assessed and met. The people living at the service had been there for a number of years and there needs had been assessed by health and social care professionals as well as by the provider on an ongoing basis. People's support needs were written in care plans to ensure staff had all the information necessary to meet people's needs. People were allocated a particular member of staff to be their key worker and had a formal meeting with them once a month in order to discuss their care delivery. These were signed by people to evidence their involvement. A person told us they were involved, they said, "I get to make decisions." There was evidence that staff took on board people's input about their care.

Care staff responded to people's changing needs by tailoring their support to them. Care records were written from the first person and contained details of their personal preferences and highly specific likes and dislikes. Changes in need were regularly reviewed and accurately recorded in support plans. Details in care records about how people wished to be supported were personalised and provided clear information to enable staff to provide appropriate and effective support. Staff we spoke with demonstrated they knew the people they supported well and we observed them following the support plans during the inspection.

People were supported to maintain their hobbies and interests. A person told us, "There is enough going on. I go into the community. I go swimming and I like bowling." A person had been supported to maintain voluntary work in their community which they enjoyed. During the inspection we observed the person living at the service taking part in activities and going out for a walk as they desired. Records we reviewed demonstrated people took part in activities such as music related to their culture, cinema trips and swimming.

Inadequate

Is the service well-led?

Our findings

Records we reviewed demonstrated that the provider's legal obligation to inform the Care Quality Commission (CQC) of significant events was not always discharged. There were significant events that affected the service, such as a police incident, that had occurred and where the service had not submitted the relevant statutory notifications to the CQC. The acting manager who has responsibility for submitting the statutory notifications could not do so because they were not aware of which events should be reported other than those relating to safeguarding concerns. The issues above relate to a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

The service was not well led and leadership was inconsistent. The service was not overseen by a registered manager as legally required. An experienced deputy manager had been appointed to act as manager two weeks before the inspection took place. The previous manager had had a pending management application lodged with the CQC but this application had not been cancelled not had we been informed that they had resigned. The acting manager had not applied to become the registered manager at the time of the inspection. The service manager had been seconded to fill a management vacancy at another service run by the provider and, as such, could not adequately fulfil their support functions to the acting manager despite a reported good working relationship.

There was a negative, non-transparent culture at the service and staff morale was low. The service was undergoing a period of change and four people who had been living at the service for a long time had recently moved out. Staff told us, "The staff are not happy because [senior] management are not communicating with them". Another told us, "No-one is talking to us about the future; we don't know what to do." Formal internal communication systems for staff to contribute their views about the running of the service and to drive forward service – wide improvements were not available. Records demonstrated staff meetings had not been conducted since September 2016. Handovers were not recorded and as such could not be monitored for trends or feedback sought. Furthermore, service user meetings had ceased which impacted on their ability to make suggestions about the improvements to the service or to be kept up to date with the changes happening at the service. This meant that communication systems were not in place to assess, monitor and improve the quality of the services provided.

The service was not organised in a way that promoted safe care through effective quality monitoring. The acting manager informed us that the service, including care files and medicines, should be reviewed by senior management on a monthly basis. Records demonstrated these were not up to date. The quality assurance inspection had not been completed since March 2017 and the health and safety audit had not been completed since June 2017. The shortcomings we found at this inspection had not been highlighted by the service and plans were not in place to remedy the issues. For example, concerns around environmental risks and seeking feedback. There was not a system in place to formally observe staff in order to give constructive feedback about how they fulfilled their roles. This meant that poor practice could not be rectified nor good practice celebrated and embedded. There were no service-wide action plans to improve safety and conditions for people living at the service.

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

It was noted that there was a good working relationship between the acting manager and staff who felt they could informally report any concerns. One staff member told us, "[The acting manager] is very good." Another said, "When something wasn't working in the home I would tell the manager and she corrects it". A person we spoke with told us "I get on with the [acting] manager." Accidents and incidents were recorded and we noted that changes had been made to service delivery as a result. This meant that low lying concerns that staff had about how people lived their daily lives were escalated and dealt with. Overall, care and support provided to people was intuitive rather than guided by good practice or long-term management support.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Care Quality Commission of events that impacted on the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because the provider did not do all that was reasonably practicable to mitigate risks and the premises used by the service provider were unsafe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been established or operated effectively to ensure compliance. Systems were not in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Fit and proper persons employed was not assured because criminal record checks were not available in relation to each such person

employed.