Hillbrook Grange Residential Care Home

Hillbrook Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hillbrook Grange is a residential care home providing personal and nursing care to 33 people aged 65 and over at the time of the inspection. The service can support up to 41 people.

People's experience of using this service and what we found
Medicines were not managed safely which placed people at risk of harm. People were not safeguarded from abuse and other risks to them. Infection, prevention and control procedures did not protect people from the contracting of avoidable infections. The environment was well presented but several health and safety risks were identified.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Processes to ensure people were not deprived of their liberty were not always followed.

People did not always receive person-centred care. Care plans had not been reviewed and monitoring records were often incomplete. Complaints were not always responded to in line with the home's policy. People told us they felt socially isolated and there was a lack of activities. We have made a recommendation about managing social isolation.

The service was not effectively managed and there were limited systems in place to monitor the quality and safety of the service provided. Staff did not always feel supported by the management team. Relatives did not always find the registered manager approachable or proactive. We have made a recommendation about the management of the closed circuit television.

The provider took steps to mitigate risk following the first two days of the inspection. For example, carrying out fire safety checks and risk assessments. There had been some improvement on day three of the inspection but medicines management was still unsafe.

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

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

Why we inspected
The inspection was prompted in part due to concerns received about safety, person centred-care, response to concerns and infection control. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hillbrook Grange on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Since the last inspection we recognised that the provider had failed to notify us about the outcomes of multiple applications to deprive a person of their liberty (DoLS). This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

We have identified breaches in relation to safety, staffing, person-centred care and governance at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Since the last inspection, we recognised that the provider had failed to inform us about notifiable incidents. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

You can see what action we have asked the provider to take at the end of this full report.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Hillbrook Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector and one medicines inspector.

Service and service type
Hillbrook Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that when registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We asked the local authority for information about the service. We

gathered information that the local authority and Healthwatch held about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke 12 people who used the service and we spoke with 11 relatives. We spoke with 15 staff members including the nominated individual (the person who communicates with CQC on behalf of the trustees), the registered manager, the deputy manager, the business manager, the activity coordinator, two housekeepers, six care staff and two office-based staff. We also spoke with two health and social care professionals for their view of the service. We reviewed a range of records including care records for eight people. We looked at medicines and records about medicines for 18 people. We spoke with the two seniors who had responsibility for administering medicines on the days of the inspection. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including health and safety records were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The registered manager provided us with staff training records and information about complaints.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- The registered manager and the provider failed to ensure people received medicines safely.
- People missed some doses of their prescribed medicines because there was no stock available in the home for them.
- There was no system in place to ensure that medicines were reconciled each month when the new medicines' cycle started.
- Systems for booking medicines into the home were not robust. One person missed having two days antibiotic treatment because staff did not know the medicine had been prescribed.
- Records about the stock of medicines were inaccurate and could not show medicines were accounted for, or had been given as prescribed.
- Medicines rounds were very lengthy. This meant that people were given their medicines at irregular time intervals. People were not always given medicines at the correct times with regard to food.
- Written guidance was not in place for medicines prescribed to be given "when required". This meant staff did not have the information to tell them when someone may need the medicine.
- Medicines prescribed with a choice of dose lacked information about which dose staff should choose.
- A system was in place to make sure that medicines administered in a patch formulation were rotated safely but staff failed to rotate them in line with the manufacturers' directions.
- Creams were not managed safely. The records about the application of creams were not completed and did not show creams were applied as prescribed
- Medicines were not stored at the correct temperatures. The staff failed to monitor the temperature of the medicine's room and it's fridge. Both were too warm for the safe storage of medicines. The medication trolley was left open and unattended during a medicines round.
- Some minor improvements were made by day three of the inspection. However, a significant number of ongoing serious concerns about the way in which medicines were managed remained at the end of the inspection.

Medicines were not effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider took immediate action to mitigate risk and improve medicines management following the inspection.

Systems and processes to safeguard people from the risk of abuse

- The registered manager and provider had not ensured that all safeguarding incidents were investigated in

line with their safeguarding policy. One person disclosed an allegation of abuse to the inspector during the inspection. The allegation was known to the management team but had not been investigated or reported appropriately. Following the inspection we passed information we were concerned about on to the local authority.
● The registered manager and provider had not shared safeguarding information with the local authority or the CQC in line with their statutory obligations.

Systems and processes did not operate effectively to prevent abuse. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed safeguarding training and knew how to report incidents of concern.
● The provider took immediate action to safeguard people following the inspection and make the necessary notifications to the CQC.

Preventing and controlling infection
● The registered manager and provider had not ensured that staff used PPE effectively and safely. On the first day of the inspection not all staff were not wearing face masks in line with best practice.
● Relatives raised concerns that staff were not adhering to social distancing rules. We saw evidence of this on the home's social media page.
● The home had an appropriate infection prevention and control policy. However, best practice identified in the policy was not always followed by staff in relation to personal protective equipment and social distancing.

Control measures to prevent infection were not effectively managed. This was a further breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider took action to ensure infection control measures were in place following the inspection. On the second and third days of the inspection staff were wearing appropriate masks.
● We were assured that the provider was preventing visitors from catching and spreading infections. Visitor's temperature was monitored and recorded by staff when they arrived at the service.
● We were assured that the provider was accessing testing for people using the service and staff.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● The registered manager and provider had not always ensured there were enough staff working at night to meet people's needs. Staff told us they could not always know the whereabouts of people to ensure their safety.
● People did not always get their medicines in the evening or at night because there was not always a senior on shift to give them. Staff had not had their competency to administer medicines checked in line with good practice.
● People told us they sometimes had to wait for care. Two people told us that staff routinely turned their call bells off then not returned to care for them. One person shared that this had resulted in an incident that impacted on their dignity. We fed this incident back to the registered manager who provided an audit showing that call bells had been turned off within minutes. However, this did not account for staff not returning to support people.

Sufficient numbers of suitably qualified and competent staff were not always deployed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely to the service.
● The provider took immediate steps to increase staffing levels at night following the inspection to ensure that people could have medicines if required.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The registered manager and provider had not always mitigated against risks to people. For example, care plans and risk assessments relating to behaviour were not robust and two people at risk of choking did not have risk assessments in place. The provider ensured that risk assessments were carried out in the areas we identified following the inspection.
● Fire safety checks had not been carried out since July 2020. The provider ensured that fire safety checks were carried out and recorded following the inspection. We saw a fire door at the top of the staircase was left open on all three days of the inspection. This presented both a fire risk and increased the risk of people falling downstairs.
● The registered manager and provider had not ensured that risks to the environment were safely assessed. A bath hoist had not been assessed or fitted with safety lap belt in line with best practice guidance. The registered manager told us that the bathrooms were being imminently remodelled and did not indicate that they would carry out an assessment or purchase a lap belt in the interim.
● The registered manager and provider had not always ensured care records and risk assessments were updated following an incident.

Risks to the health and safety of service users was not safely assessed. This placed people at risk of harm. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team had referred people to appropriate healthcare services in some cases. For example, staff sought the advice of the mental health team to support the needs of one person at the home.
● The provider had arranged referrals to appropriate professionals for the people we identified following the inspection.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The registered manager and provider had not ensured people's care plans had been reviewed. This meant people could not be assured they would receive appropriate care and support.
- People's care tasks were not accurately recorded or monitored. However, people appeared to be well cared for during the inspection. Two health and social care professionals told us that people were well presented when they visited the home.
- Two health and social care professionals told us they had recommended the monitoring of specific issues but they had not been completed. For example, Staff failed to complete continence charts for one person when asked to do so.
- One person was at risk of self-neglect. The management team had not explored or recorded strategies to manage behaviours leading to this risk. A care plan and risk assessment was carried out following the inspection.
- One person was moved to a different room for several days to facilitate visits from relatives. Staff did not move their personal effects with them. This meant the person was in an empty room without familiar items to provide comfort and reassurance.
- Authorisations to deprive a person of their liberty had not always been made to the relevant bodies.
- Some people had end of life care plans in place but more detail was required to ensure all wishes were captured.
- Relatives told us that the management team had expected people to isolate in their bedrooms after attending out-patient appointments. One relative told us, "Policies for isolation are inconsistent and penalising. We feel discouraged from accessing health care appointments". The provider told us that some information given to relatives had been incorrect and up to date advice was now available on request.

People did not receive always personalised care and treatment. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us that the management team had expected families to make referrals to other health care professionals for people living at the home. We told the provider about this on the third day of the inspection we saw that the provider had made appropriate referrals for two people at the service.
- People told us they had a choice of food and they enjoyed the range of food available.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People told us they were lonely and they spent too much time in their rooms. The registered manager told

us that people were allowed to use the home's facilities on alternative days to help control the spread of infection. This meant people spent alternate days in their bedrooms. The impact of social isolation on people's wellbeing had not been risk assessed by the management team.
● People told us that they enjoyed activities when they took place but wished there was more to do. The management team had gathered this information from people prior to the inspection but had not actioned it due to anxiety around allowing people to mix with each other during the pandemic.
● We told the provider that people felt isolated and on the third day of the inspection we saw people were taking part in more activities and were no longer isolated to their bedrooms on alternate days.
● Seven relatives were happy with the level of communication the management team had facilitated with their loved ones. however, Six relatives told us they were dissatisfied with the limited opportunity for window visits, telephone and video call contact throughout the pandemic.

We recommend that the provider consider current guidance in relation to managing social isolation, wellbeing and social distancing.

Improving care quality in response to complaints or concerns
● Complaints were not always responded to in line with the home's complaint policy.
● We received mixed feedback about the response to complaints. Three relatives told us that they had raised issues that were resolved quickly. However, one relative told us that the registered manager had not responded to their complaint at all. Two relatives told us that the registered manager had not returned their telephone calls when they raised concerns. The registered manager told us that they always returned people's calls.
● The registered manager took a significant length of time of five days to provide us with the complaints log whilst they updated this with their responses.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and provider had failed to notify the CQC about incidents as required under their registration. The CQC had not been notified about safeguarding allegations or authorisations to deprive people of their liberty.

The registered manager and provider did not notify us without delay of incidents that occurred during the carrying on a regulated activity. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

- The registered manager shares legal responsibility for people's safety at Hillbrook Grange with the provider. The registered manager and provider had no oversight of the significant shortfalls in medicines management at the home. The registered manager told us they had delegated the management of medicines to another member of staff despite being accountable for medicines management under their registration.
- Audits to check medicines had not taken place. This meant that risks associated with the management, storage and administration of people's medicines had not been identified by the registered manager or provider, or rectified.
- Staff administering medicines had not had their competencies checked or had received recent training.
- The medicines policy did not include sufficient information to ensure medicines were managed safely.
- The registered manager told us they had misunderstood safeguarding processes so had not processed incidents or allegations appropriately. There was a culture of minimising incidents. For example, the police had been called to support with the behaviour of one person but this was not reported appropriately. Training records indicated that the registered manager had completed safeguarding within12 months of the inspection.
- Audits to monitor health and safety had not identified risks relating to environmental and fire safety.
- The provider did not have effective oversight of the service and systems were not in place to monitor the performance of the registered manager.

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

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

● Staff held a variety of views about the culture and leadership at the home. Some staff told us they felt well supported by the registered manager and told us about a number of staff incentives. One staff member said, "[Registered manager] has been really supportive to me on both a professional and personal level." Other staff felt that management approach did not welcome feedback and there was a culture of bullying.

● Four staff members told us that they did not always feel able to be open when things went wrong in case they were blamed.

● The registered manager and provider had fitted closed circuit television (CCTV) internally and externally to the building, including the new 'visiting' gazebo. CCTV recorded audio and footage and had not been installed in accordance with General Data Protection Regulation principles. Following the inspection the provider arranged to have the CCTV removed from the gazebo and disable the audio facility throughout the home in consideration of people's right to privacy.

We recommend the provider consider current guidance on CCTV and further update their practice accordingly.

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

● Relatives offered conflicting views about their engagement with the management team at Hillbrook Grange. Seven out of 11 relatives were satisfied. One relative told us, "The staff always call me to give me essential updates if there is anything I need to know about [Name], I have no complaints". However other relatives felt the attitude of the registered manager was uncooperative and restrictive. One relative said, "Relatives are not seen as important and input into our loved one's care is heavily controlled by the management team."

● The registered manager and provider had not always updated people and relatives in a timely way following an incident.

● People were consulted on a monthly basis to review their care. Their feedback was considered by the management team but did not always lead to effective changes. For example, people had said they wanted more activities on several occasions, but no extra activities had been provided.

● People, relatives and staff told us they had not been recently consulted with or given consent to be monitored by the CCTV at the service. One relative said, "The fact that visits are captured on CCTV is characteristic of the management team's 'over the top' approach to visitation."

● The registered manager had held staff meetings where staff could raise issues and information could be shared.

Working in partnership with others; Continuous learning and improving care

● Two health and social care professionals told us they had initially struggled to gain access to the service despite making appointments to assess people for essential treatment. Staff at the home were concerned about infection control but had eventually granted them access.

● The registered manager did not check that audits and records were completed effectively so areas for improvement were not always identified. Management practice at Hillbrook Grange did not lead to real change within the service and did not reflect a culture of continuous improvement.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager and provider failed to notify the Care Quality Commission without delay of the incidents which occurred whilst services were provided in the carrying on or a regulated activity. Regulation 18 (1)

The enforcement action we took:

We issued a fixed penalty notice.