Park Avenue Ltd

Hill House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hill House is a residential care home, providing personal care and accommodation for up to 13 people with learning disabilities and/or autistic spectrum disorder. There were 12 people living at the home at the time of our inspection. The home was divided into three separate floors for people who used the service, with lounges, sensory rooms, activities rooms, gardens and dining room areas.

The service had been registered since October 2010, however, the provider was not taking into consideration the principles and values that underpin Registering the Right Support and other best practice guidance for the accommodation of people with learning disabilities. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

People's experience of using this service and what we found
Since our last inspection visit, we had received concerning information that indicated people did not always receive personalised care, specifically around the lack of skilled staffing levels and risk management.

People and staff did not always feel safe at Hill House. Staff did not always understand how to keep people safe and reduce potential risks to people. Risks associated with some people's care were not managed safely. People's individual needs, health conditions and complex behaviours, had not always prompted risk management plans to be in place.

People did not receive person-centred care from staff, as staff lacked the skills and training they needed, and the guidance they needed to ensure people were supported according to their personal needs.

People were not always involved in choosing their care and support, from pre-admission to living in the home. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

The staff team did not always prevent people from becoming socially isolated within the home. People did not always have their privacy and dignity respected. People were not always encouraged to be independent and make everyday decisions about how they wanted to live their lives.

People and their relatives knew how to raise concerns and provide feedback about the service, and there was evidence that concerns had been raised with the manager of the home. However, concerns were not documented in a complaints log, which did not promote an understanding of how concerns were being addressed and learned from.

The previous registered manager had left the provider's organisation several weeks before our inspection visit. The service was led by a manager who had been in post for five weeks, and a deputy manager. The provider was not offering the support and guidance needed at the home, to the staffing team and the new manager. There was a lack of effective auditing procedures in place to identify issues and areas for improvement at the service.

Although some risks to people, and the need to update care records, had been identified by the new manager and the provider before our inspection visit, action to mitigate risks to people's safety had not been resolved in a timely way, and whilst problems continued, additional measures to reduce risks had not been taken by the provider. Following our inspection, measures were put in place and a review of the service commenced.

Rating at last inspection
The last comprehensive inspection report for Hill House (published April 2019) we gave a rating of good in all areas. At this inspection we found the service had deteriorated and have rated the service as inadequate.

During this inspection visit, we found the safety and quality of the service had deteriorated and some people's care outcomes were not of a good standard. The service is now rated Inadequate. We identified breaches of the Health and Social Care Act 2014 (Regulated Activities):

Regulation 10 Privacy and Dignity
Regulation 11 Need for Consent
Regulation 12 Safe care and treatment
Regulation 13 Safeguarding
Regulation 17 Good governance
Regulation 18 Staffing

Why we inspected
This inspection was a responsive inspection prompted in part due to concerns received about safeguarding alerts and investigations that were notified to CQC. This included incidents of challenging and violent behaviours. We were also notified of the findings of a recent compliance inspection by the local authority where the service was rated as Inadequate. A decision was made for us to inspect and examine those risks.

We found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner. 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 effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring 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

Hill House

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection Team
The inspection team consisted of two inspectors and an assistant inspector.

Service and service type
Hill House is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service did not have a manager registered with the Care Quality Commission (CQC) in post at the time of our inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection took place on 29 October 2019 and was unannounced.

What we did when preparing for and carrying out this inspection
We reviewed information we had received about the service since the last inspection. This included information received from the provider about specific events which included deaths, accidents and incidents and safeguarding alerts which they are required to send to us by law. We reviewed the feedback we had received from relatives of people who lived at the service, and local professionals who had regular contact with people who lived at Hill House.

We requested feedback from the Local Authority quality monitoring officers. The local authority had undertaken a visit in September 2019 and found areas where they rated the service as inadequate. Improvements were required in record keeping, risk management, environmental management and quality assurance. Identified improvements related to people not always receiving the support they needed. We

used all the information to plan our inspection visit.

During our inspection
We spoke with four people living at the home. Some people, due to their complex care needs and disabilities were unable to give us their feedback about the home. We spent time with people to see how staff supported them. We also spoke with four members of staff including the chef, deputy manager and the manager.

We reviewed a range of records, including three people's care records and four people's medication records. We also looked at records relating to the management of the service, including audits and systems for managing any complaints. We reviewed the provider's records of their visits to the service; and records of when checks were made on the quality of care provided.

Following our inspection
We spoke with the provider and the nominated individual regarding our findings at the inspection visit. We gathered additional evidence from the manager, which we used in our inspection report. We also received feedback from the provider and their nominated individual on the plans they had in place to immediately improve the service. We received feedback from two care workers.

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 Good. At this inspection we found the rating had deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Important information about managing risks of harm or injury was not always available for staff to refer to when needed. For example, risk assessments and risk management plans were not always in place to instruct staff on how to protect people. For example, one person was at significant risk of harming themselves and others. The person had moved into the home in December 2018, and since that time the manager told us there had been two incidents where staff required medical support following a physical interaction with the person. The person had also had physical altercations with more than two other people who lived at the home. Following the incidents, the provider had failed to ensure they provided staff with the information and skills they needed to care for the person in a safe way, protecting them and others from harm.

● In addition, the provider had failed to act in a timely way in seeking support from other agencies such as psychology input, commissioners of services, learning disabilities and autism specialists, or health care professionals, to mitigate the risks the person caused to themselves and others. The new manager had begun to seek specialist advice in how to support the person safely since their appointment five weeks before our inspection visit. Following our visit, the provider brought in specialist support to assist staff and the new manager in devising positive support behaviour plans that were person centred.

● Staff did not always protect people from risk of harm; where they were instructed to do so. For example, we saw one person was at risk of having epileptic seizures. One of the triggers of such a seizure was listed in the person's risk management plan for the condition as being tired. We saw records of an incident in December 2018 where staff had continually woken the person; or prevented them from sleeping. The person had become anxious and lashed out at staff in a violent manner, however, staff had continued to stop the person from sleeping.

● The provider had failed to ensure environmental risks to people were sufficiently assessed and mitigated against to ensure people were always cared for safely. Some people had a diagnosis of a learning disability and some were living with autism and anxiety, which meant they displayed behaviours that could cause themselves or others injury. As most people were able to move around the home without assistance from staff it was important the environment was safe. We observed a cleaning trolley on the first floor, where cleaning chemicals were stored was left unsupervised, which did not prevent people accessing potentially injurious chemicals.

The above concerns were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

● Staff were recruited safely. The provider completed checks to ensure staff working at the home were suitable.

● The provider had systems to minimise risks related to the premises and equipment, such as periodic safety checks of gas, water, fire and electrical equipment in line with safety guidance.

Systems and processes to safeguard people from the risk of abuse

● Staff did not all understand the processes and procedures around how they should safeguard people from the risk of abuse. Staff did not always demonstrate an understanding of safeguarding principles. One staff member told us they could not remember if they had received safeguarding training at Hill House.

● Staff members told us they would report any instances of abuse or potential abuse to the manager of the home, however, one member of staff told us they had previously raised concerns that had not been investigated by the former registered manager. The staff member, nor the previous registered manager had escalated their concerns to a relevant authority when the registered manager did not act to protect people.

● Staff were operating potentially abusive practices towards people at the home, which was not being prevented by the provider. We found more than four records of incidents where one person had shown abusive and violent behaviour to staff and others at the home. According to the incident reports staff had recorded, the person had been threatened with isolation by securing them in their room, and on another occasion had been isolated and secluded from others in this way. There was no evidence to suggest this approach to managing their behaviours was beneficial to their emotional health and well-being. The instructions to seclude the person from others was not detailed in their positive behaviour plan.

● Staff were not provided with guidance and information on how they should protect people from the risk of abuse. On one occasion a person, who lacked the capacity to make decisions about their safety, had been allowed outside of the home alone with a visitor unknown to staff, without staff support; staff were aware the person was not safe to leave the premises without staff support. Staff did not know where the person had been taken. The person was at risk due to their complex diagnoses and vulnerability. Although staff had since been briefed by the new manager that this should not happen again, we saw the incident had not been reported at the time it occurred. The incident has now been reported, and has been investigated by the new manager, however, there was still no risk assessment and risk management plan in place to instruct staff on whether the person was at risk from visitors, and how staff should manage requests for the person to be taken out of the home. This was significant, as it continued to place the person at risk, and the home used agency and temporary staff on a regular basis who may not know people well.

The above concerns were in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

● The new manager understood their responsibilities in reporting specific incidents to us, commissioners and the local authority. Since their appointment at the home, five weeks prior to our inspection, they had reviewed previous incidents and concerns at the service, and had referred information to commissioners, the safeguarding team, and to CQC, as they were required to.

● Following our inspection visit the provider had arranged immediate re-training for staff at the home in safeguarding people from abuse, how to support people with anxiety and behaviours that may be challenging to others. The provider had also implemented a review of each person's care and support needs, and how these could be met in the future. New care records and risk assessments were being drafted before the end of November 2019.

Staffing and recruitment

● Prior to our inspection visit, we had received concerns from relatives who felt there were not enough skilled and experienced staff on shift to care for people safely. Whilst staff understood distraction techniques in managing distressed behaviours, we saw they were not skilled at managing challenging and potentially aggressive behaviours. One person displayed agitation in the communal area of the home; staff did not

respond to re-direct their attention into positive interactions, or into activities they enjoyed. The person continued to display agitation and anxiety. This placed the person and others at risk of harm.
● Because some members of permanent staff were unable to work with one individual due to their complex behaviours, the provider used agency or temporary staff to support people. The provider had failed to take into consideration the effect of using temporary staff for people at the service, as they may not know them well. This lack of knowledge was important, as care records and risk management plans for people were not kept up to date.
● Over a five-day period in October 2019 records showed temporary staff covered more than 50% of daytime staffing levels. On one day five out of seven staff were temporary staff.

The above concerns were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

● Following our inspection visit the provider brought in managerial support to the home from their operational management team. They also brought in specialist nurses who had experience in learning disabilities services, and in caring for people with autism. The provider intended to recruit a nurse with these skills to work at the service five days a week, to support staff at the home. In addition, the provider had begun a recruitment procedure, and intended to recruit more permanent care staff for the home.

Learning lessons when things go wrong
● The provider had a system for staff to report accidents and incidents. However, their analysis of accidents and incidents at the home had failed to ensure safeguarding incidents were investigated and reported as required. An analysis of previous incidents had also failed to ensure people were offered the right treatment and support from health care professionals.
● The provider had not ensured their analysis of accidents and incidents was used as effectively as it could have been to ensure learning was identified and risks of reoccurrence minimised.

Preventing and controlling infection
● Staff had completed infection control training and had personal protective equipment available to them. Staff used gloves to reduce risks of spreading infection, for example, when undertaking personal care.
● On the day of our inspection visit, there were no unpleasant odours in the home.

Using medicines safely
● People had their prescribed medicines available to them and were only given them by staff trained in safe medicines management. Medicines were stored safely. Where staff administered medicines, they recorded the medicines that had been given accurately.
● Some people were prescribed 'when required' medicines. There were clear instructions on when thee medicines should be given to people. However, we found one person was prescribed a medicine for epilepsy, to reduce the risk of increased seizures. The person's medicines were not appropriate for them, as they were prescribed for people under the age of 18. The person was 19 years of age which had not been queried by the provider. We have asked the manager to review the use of this medicine with the assistance of a doctor.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to inadequate. This meant the effectiveness of people's care, treatment and support did not achieve good outcomes and was inconsistent.

Ensuring consent to care and treatment in line with law and guidance The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's capacity to make decisions had not always been assessed, although it was clear from our observations that some people at the home lacked the capacity to make complex decisions. For example, people's capacity to understand risks associated with their care. Some people had been asked to give their consent to aspects of their care and treatment, where there were clear concerns indicated in their care records around whether they lacked the capacity to make informed decisions about their care and treatment.
- Some people at the home had been assessed by the manager as requiring a DoLS, to restrict their actions for their safety. DoLS applications had been made for 11 people who lived at Hill House. In these DoLS applications, it was clear people were unable to leave the home without staff supervision, as this placed them at risk. One person at the home was able to go out alone, if they wished. Staff members did not understand who had restrictions placed on them, as one member of staff said, "No-one here can go out on their own."
- Some 'best interests' decisions had been made with the involvement of relatives and staff, however, these decisions and the reasons for them were not consistently recorded. Other decisions that had been made on behalf of people living at Hill House were not always in their best interests. For example, one person's relative, who did not have a power of attorney in place, had given instructions to staff on how their relation should be cared for which had been actioned. Staff had not considered whether this put the person at risk of harm or neglect.
- Information about people's legal representatives had not always been checked and documented.
- During our inspection visit we saw there was surveillance systems in operation at the home, that people at the home and their relatives had not all agreed to. The provider had not ensured they had the legal authority to monitor people in this way. When we raised this with the manager on the day of our visit, and they turned the systems off. The provider planned to conduct a full consultation with people and stakeholders before

they decided how to use the CCTV system in the future.

The above concerns constituted a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11, Need for Consent.

Supporting people to eat and drink enough to maintain a balanced diet

● Some people showed enjoyment in their lunchtime meal. Some people had adapted tools to assist them to drink independently, such as specialist cups, which promoted people's dignity and independence.

● People's nutritional and hydration needs appeared to be met, as people looked healthy and alert during our inspection visit. However, we received feedback from one relative who was concerned their relation did not always have access to drinks when they needed them. They said, "I have found [Name] drinking from taps before, due to being thirsty."

● We observed there were no drinks and snacks available in the communal areas of the home for people to help themselves. The manager told us this was because of people's complex diagnoses, as people could pick up and throw objects, or excessively eat and drink. However, the manager explained people could ask for drinks and snacks whenever they wished or access them through a hatch to the locked kitchen. We saw however not everyone had the ability to verbally request snacks and drinks. One person was thirsty and attempted to drink from another person's cup, staff then offered the person a drink of their own.

● Where people had specialist dietary needs, either due to religious, cultural or health reasons, their meals were prepared by a chef who knew people's requirements and could describe how they prepared different meals for people on a daily basis, to meet their preferences.

Staff support: induction, training, skills and experience

● Staff received an induction and training when they began working at the home. However, staff did not always feel this gave them the skills they needed to effectively support people. Staff felt more in-depth training and management of behaviours that could challenge, would benefit staff and people at the home. Following our inspection visit the provider had organised increased training for staff in managing people's behaviours, and safe ways of preventing people from injuring themselves and others.

● Staff were offered regular supervision meetings with the new manager which had been implemented before our inspection visit. The new manager told us regular supervision meetings were held to discuss staff concerns.

● Staff confirmed they did not have the skills they needed to effectively support people. Comments from staff included; "Staff just have to either put themselves in the way [to protect other people] or try and remove [Name] from people if they are being aggressive. This is not done by using any trained technique", "Some staff don't want to support [Name] as they have been injured", "I try not to give her eye contact", and "We have to get everyone out the way. People are scared, and it upsets them."

● Following our inspection visit the provider arranged staff re-training in how to support people to manage their anxiety, to prevent people from becoming aggressive and causing harm to themselves and others.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had a pre-assessment before moving to live at the home. These assessments were used to formulate care plans for staff to follow. However, we found these were not always adequate in determining whether the person's needs were able to be met by the provider. For example, one person had recently been admitted to the home, and the staff and manager found they could not meet the person's needs, the manager was looking to place the person in alternative accommodation.

● The provider had failed to recognise how the introduction of several new people at the home, would impact on the wellbeing of all the people who lived at Hill House. The manager told us, "Since more people were introduced to the home at the end of 2018, it has affected people's behaviour." One relative told us

their relation now urinates in their bedroom. They said, "This was not something they did before."
● During people's initial assessment they were given the opportunity to share information with the provider and staff to ensure there was no discrimination, including in relation to protected characteristics under the Equality Act (2010).

Adapting service, design, decoration to meet people's needs
● Some areas of the home had been adapted to meet people's needs, such as the development of quiet areas and sensory areas. People could also access a secure garden area. However, some areas of the home were not designed specifically to meet people's needs, including toilet facilities.
● People were supported to personalise their bedrooms, however, some people who had a diagnosis of autism and behaviours which meant they may destroy objects in their room, had bedrooms that required improved decoration to make it homelier. For example, one person had black plastic on their window rather than blinds or a decorative privacy screen. A visiting professional told us, "The heater has been removed from [Name's] bedroom, as they can play with it. However, this means their room is now very cold."

Supporting people to live healthier lives, access healthcare services and support;
Staff working with other agencies to provide consistent, effective and timely care
● People did not always receive timely and effective support from health professionals where a need had been identified. For example, one person had been admitted to Hill House in December 2018. Records showed since their admission to the home there had been several instances of aggression, anxiety, and them injuring staff and other people who lived at the home. The provider had failed to act in a timely way in seek support from other agencies such as psychology input, commissioners of services, learning disabilities and autism specialists, or health care professionals, to mitigate the risks caused to themselves and others.
● The manager and staff told us people received care and treatment from health and social care professionals who visited the home regularly. These included district nurses, speech and language therapists and social workers. Where people required referrals to other health professionals such as the GP, dentist and chiropodist, these visits were organised by the manager. The manager told us they had begun a review of everyone's requirements to see health professionals, to ensure people had regular appointments in place.
● There was not a full record of when health professionals visited the home, and what advice and support should be actioned by staff following their visit. The new manager explained they now had a system in place for visitors to the home to sign in when they arrived, and a section in people's care records for health professionals to write what advice and support people required following their visit, and what treatment people received.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to inadequate. This meant people did not feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was not always respected. We saw one person being assisted to use the toilet during our visit, in full view of people, staff and visitors. A care worker was assisting the person; but had failed to close the door or protect their privacy by use of a privacy screen, or by asking people to use a different route in the home, so the person could not be seen. We raised this immediately with the manager and asked them to protect the person's dignity. They later confirmed this was usual practice saying, "This happens because [Name] likes to use that toilet and it's not big enough for us to assist them in there with the door closed." The toilet was then taken out of use. We noted there were other usable bathroom and toilets in the home that could have been utilised. We were concerned that staff and managers had failed to recognise the practice did not respect the person's privacy and dignity, and the person lacked the capacity to understand how their exposure to others may cause embarrassment or anxiety. Following our inspection visit the downstairs toilet had been closed, until alternative arrangements could be made to enlarge the space, or to protect people's privacy whilst using the toilet.

● When we arrived at the home CCTV surveillance was in use in the communal areas of the home, where people were being supported by staff. As people at the service sometimes displayed behaviours that may cause privacy issues, such as removing their clothing in communal areas, the use of CCTV did not respect people's privacy and dignity.

● The provider demonstrated a history of monitoring people covertly in their private bedrooms. Before our inspection visit the new manager had turned off visual monitoring systems that were in place in one person's bedroom. This visual monitor had been installed following the wishes of a parent, without due consideration of the person's right to privacy, and what may have been in their best interests. We were unsure how long this surveillance had been in operation at the home, and who may have had access to the images whilst they were displayed.

● Following our inspection visit the provider had turned off all CCTV monitoring at the home, until a full review and consultation could be undertaken into its use, and whether this was in people's best interests.

● The provider failed to protect people's privacy, as they did not store care records and personal information securely. During our inspection visit we saw a store room which contained care records and personal data was left open, and was accessible to staff, people and visitors. We asked that the room be kept locked to protect people's personal data.

● People were not always treated with respect, as their wishes were not always taken into account when being supported by care staff. For example, one person was being supported to eat their lunchtime meal. We saw the person was not interested in the food on offer. Staff said, "Come and sit down and eat your dinner, sit down, sit properly, pay attention to what you are doing, eat your food." The language used with

the person did not show respect to the person, acknowledge the person may have preferred to eat at a different time or take part in an alternative activity.

The above concerns constituted a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 10, Dignity and Respect.

Ensuring people are well treated and supported, equality and diversity

- People told us, or indicated to us with gestures, they liked permanent staff at the home. One person said, "I like [staff member] she's my friend."
- There was not always a caring culture at the home, as people were not always supported in a caring way. The culture at the home was affected by a lack of proactive action by the provider to ensure people were always cared for safely, and people and staff were protected from physical and emotional abuse. For example, staff told us they had raised their concerns over past months with managers about the safety of people and staff, which had not been actioned.

Supporting people to express their views and be involved in making decisions about their care

- People were not always supported to make their own decisions about their care, where they could. Care records did not show how people were involved in reviews of their care and making their preferences and wished known to care staff.
- The manager explained people at the home were now being invited to take part in decisions about the décor of the home, how their rooms and personal spaces were decorated, and what group activities and events they may enjoy through resident's meetings.

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 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

- People had individual care plans. However, these did not consistently provide staff with up to date information about the support each person required to provide individualised care. Care plans did not always provide an accurate and consistent account of how staff should support the person. Risk assessments and care plans were not always consistent and provided staff with conflicting information.
- Care records did not show how people had been involved in shaping their care, according to their preferences.
- The provider began a review of people's care and support needs, and of care records following our inspection visit. Care records and risk assessments, including risk management plans, were being updated for all people at the home before the end of November 2019.

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

- The manager told us they had introduced an activities programme at the home one week before our inspection visit. They explained they felt people needed more activities to engage them, so that they were less bored.
- The activities programme was designed to encourage people to take part in activities, events and hobbies they were interested in. Each person at the home had a weekly programme, which offered them time alone, time with staff in sensory areas and craft activities, and time in the community. Some people left the home several days a week, during term time, to attend local schools and colleges. Some people also visited their families regularly.
- It was unclear whether people were involved in deciding what type of activities they wanted to engage in. One person explained to us they were often bored at the home. We saw another person who paced the communal areas of the home for several hours during our visit, who was not engaged in any meaningful activities during this time. The person was supported on a 1 to 1 basis by staff, who had an opportunity to spend time with the person to conduct an activity, engage with the person socially, but we saw this did not take place. Another person was sitting in the dining room area of the home for two hours during our visit. We saw during this time the person was not engaged in conversation, or any activity by staff who regularly passed them by. Staff regularly missed opportunities to engage people in conversation and reduce their social isolation.
- We asked to see two people's individual activities plan, which was designed to be displayed in their bedrooms, so that they could understand their daily routines. Both people we asked to see, were unable to show us what their weekly programme was, as they did not know. One person showed us a blank activity chart for each day of the week in their room.

● We looked at some of the activities people engaged in. As some people had autism, structures and routines may be important to them to manage their anxiety levels. One person walked regularly with staff, and went to see relatives, but there did not appear to be an agreed time or routine to these activities.

Meetings people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability.
● There was signage around the home. Bathrooms had signage to help people find toilets.
● People at the home were offered communication cards, picture cards, and documents in easy to read format to assist them to communicate.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy, and this was displayed. The new manager told us family members had raised concerns about the care of their relations which required investigation and had been looked at through safeguarding procedures. However, these were not documented as complaints. The manager told us there were no complaints recorded in their complaints monitoring systems for the past year. This lack of monitoring of complaints did not provide the manager and provider with an opportunity to learn from feedback.
● We received mixed feedback from people's relatives about whether the previous registered manager and the provider had responded to their concerns with a willingness to learn and improve the service.

End of life care and support
● The home did not specialise in end of life care. However, the provider aimed to support people's wishes to remain at the home for end of life care whenever possible and in line with people's wishes.
● People and their relatives were given opportunities to share information about their preferences for end of life care.

Inadequate

Is the service well-led?

Our findings

At the last inspection this key question was rated good. At this inspection this key question has deteriorated to inadequate. This meant the service was not well managed and well led. Leaders and the culture they created did not promote high-quality, person-centred care.

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

● There was not a registered manager in post at the time of our inspection visit. They had left the service in September 2019. Another registered manager from a service within the provider group had been brought in to make changes and improve the service. The new manager had been in post for 5 weeks and had the intention of registering as the manager of Hill House.

● Following a recent visit in September 2019 by the local authority commissioners of the service, the home had been given an action plan of improvements they needed to make. We saw the new manager had already made some improvements at the home to the environment, and some spare rooms had been turned into a quiet lounge, sensory room and activity room.

● The provider had systems of auditing the safety and quality of the service, and the manager, deputy manager and the provider's quality assurance team undertook audits. However, these were not always effective in identifying where improvements were needed. For example, the audits had not identified all the improvements that were required before the local authority commissioners visited the home. Audits had not identified additional improvements from our inspection visit, including the use of toilet facilities, the privacy and dignity issues that were identified, the need for additional managerial and specialist support, and staff training and development requirements.

● Quality assurance checks on care records had identified that care records needed to be brought up to date, and risk assessments needed to be updated to accurately reflect individual risks to people. However, care records and risk assessments had not been brought up to date in a timely way, so that they reflected the support people needed. Following our inspection visit the provider brought in two operational managers and a learning disability nurse to review all care needs, risks, and write new care records and risk management plans, for each person at the home.

● Quality assurance checks had not identified that the review of CCTV usage at the home needed to be undertaken, to protect people's rights and protect their privacy.

● People had a pre-assessment before moving to live at the home. These assessments were used to formulate care plans for staff to follow. However, we found these were not always adequate in determining whether the person's needs were able to be met by the provider. The provider had failed to review its assessment procedures, to prevent the inappropriate placement of future people at the home. We saw that one person who had been brought into the home was due to be removed from Hill House as the new manager had sought a new living arrangement for them, due to their complex care and support needs that could not be met at Hill House. They had been living at the home since December 2018.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● The provider had not instilled a clear vision of their values, and how people should be supported by staff at Hill House. Staff did not always recognise how they could support people to include them in decision

making and keep them safe from abuse. The provider needed to ensure staff embraced values that respected people's dignity, privacy and independence.
● There was not always a caring culture at the home, as people were not always supported in a caring way. The culture at the home was affected by a lack of proactive action by the provider to ensure people were always cared for safely, and people and staff were protected from physical and emotional abuse. For example, staff told us they had raised their concerns over past months with the registered manager about the safety of people and staff, which had not been actioned.
● The service had been registered for several years. The provider was not taking into consideration the principles and values that underpin Registering the Right Support and other best practice guidance for the accommodation of people with learning disabilities. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

The above concerns constituted breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17, Good Governance.

● Following our inspection visit, the provider took immediate re-active action to improve services at the home. Two days after our inspection visit the provider brought in a positive behaviour support coach, a senior clinical lead nurse with experience in learning disabilities, and two additional managers to provide immediate support at the home to manage risks. In addition, the provider organised a quality assurance review of the service and a review of all care records and risk assessments.
●The provider assured us support would be offered to staff at the home through the appointment of a nurse to provide experienced support to staff in learning disabilities and autism, and operational management support two days a week to offer management support for the foreseeable future.
● New auditing procedures were being implemented, which included a review of care records every two months, a regular review of safeguarding concerns and incidents, weekly audits and spot checks of frequently used paperwork,
●The manager told us at our inspection visit they did not use restraint practices for people at the home. However, we saw the provider had a restraint policy, to instruct staff on how people could be assisted safely if they became aggressive. The manager told us, after our inspection visit, the provider was also offering all staff updated training in disengagement training, before the end of November 2019. Additional training had also been organised for permanent and temporary bank staff to increase their skills in understanding learning disabilities and how to adapt communication techniques for people's specific needs.
● The new manager, who was registered at another of the provider's services, understood their regulatory responsibilities. For example, they ensured that the rating from the last Care Quality Commission (CQC) inspection was prominently displayed, there were systems in place to notify CQC of serious incidents at the home.
● The provider had responded appropriately to CQC regarding requests for information.

Continuous learning and improving care
● Provider level oversight had not always ensured actions to mitigate identified risks were carried out in a timely way. For example, where people had sustained injuries, information and analysis had not always been used to ensure risks were mitigated to reduce risks of reoccurrence.
● At a previous inspection we had asked that the use of CCTV at the home be reviewed, and a consultation undertaken to assess whether this was in people's best interests and met their needs. However, we found this had not been completed in a way that ensured people's privacy and rights were protected.

●The manager and provider had an improvement plan in place to improve the home. This included the development of garden areas and a wellbeing room.
● Following our inspection visit the provider was drawing up a comprehensive action plan to make improvements to staff training, management and specialist support at the home, care records, risk assessment procedures, and auditing programmes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The manager told us relatives, people and staff could visit them at any time. People told us, or expressed with gestures, the manager was approachable.
● The manager had procedures in place to gather feedback from staff, people and their relatives. These systems included holding regular staff and resident meetings at the home, and sending out 6 monthly surveys to people, stakeholders, staff and relatives. We saw in recent resident and staff meetings the manager had asked for feedback and had acted on people's preferences. For example, people had been able to make choices about how the home was re-decorated.
Working in partnership with others
● The service had links with external services. These included access to best practice guidance, commissioners of services, nurses and health professionals. However, these links were not always used in a timely way to seek support for people when required.
● The new manager was seeking opportunities to work with other bodies to increase people's enjoyment in life. For example, local schools and community centres, religious organisations and charities to increase people's opportunities for social interaction. However, feedback from people and staff showed improvement was needed to ensure people had enough opportunities to enjoy each day.

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 10 HSCA RA Regulations 2014 Dignity and respect 10.2.a. The provider did not ensure people using their service were always treated with dignity and respect, in particular ensuring the privacy of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 11.3. You had failed to ensure the care of service users was provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12.2.a.b.The provider had not always assessed the risks to the health and safety of service users; the provider had failed to do all that was reasonably practicable to mitigate such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17.1.a.b.c.Systems or processes were not operated effectively to assess, monitor and improve the quality and safety of the services provided, or assess, monitor and mitigate the risks relating to the health, safety and welfare

	of service users and others. Systems did not ensure the secure maintenance of an accurate, complete and contemporaneous record in respect of each service user, including decisions taken in relation to the care and treatment provided.
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18.2. You had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet people's needs.