Hillgay Ltd

Hilgay Care Home

Inspection report

Hilgay
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Date of inspection visit:
02 July 2019
10 July 2019

Date of publication:
30 July 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hilgay is a residential care home providing accommodation and personal care for up to 35 older adults living with frailty, dementia and other health related conditions. At the time of the inspection there were 11 people living at the home.

People's experience of using this service and what we found
The service was not well-led, the provider lacked oversight of the care people received. Required improvements had not been made which affected the safety and experiences of people living at the home.

Systems to monitor the quality and safety of the provider's continuous improvement were not effective. The systems did not proactively monitor areas where the care delivered was not safe or meeting standards. This had led to repeated cases of people being exposed to risk.

There had been a recent instability in the management arrangements at the home, leading to significant shortfalls in the leadership of the service which staff told us, had resulted in feeling "low in morale," "stressed," and feeling, "unsafe." A new manager had been in post since 20 June 2019 during which time they had started to develop positive relationships with people, relatives and staff.

People remained at risk as identified risks to them had not been safely reduced. Risk management processes were poor and specific risks to people's health such as skin damage had not been effectively managed, and people had experienced harm.

Medicines were not managed in line with regulatory requirements and best practice guidelines.

Staffing levels were not always aligned to people's assessed needs. People and staff said they felt there was not sufficient staffing to meet people's needs.

People were protected by staff who were trained in safeguarding. Staff described to us scenarios where they had made alerts to the local authority when they had concerns about people's welfare.

There was a robust recruitment programme which meant all new staff were checked to ensure they were suitable to work with people.

Our observations during the inspection, were of positive and warm interactions between staff and people who lived in the home. Staff treated people with kindness, dignity and respect and spent time getting to know them and their specific needs and wishes. One person said, "The staff are very good and very hard working, very helpful."

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

Rating at last inspection and update
The last rating for this service was inadequate (published 3 July 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made/sustained and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of unsafe medicines, staffing levels, staff competency and infection control. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We have found evidence that the provider needed to make improvement. Please see the Safe and Well Led sections of this full report.

Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection. The overall rating for the service has remained 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 Hilgay care home on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to the arrangements for keeping people from harm to self or others, the management of medicines, deployment of staff and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review.

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

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Hilgay Care Home

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.

Inspection team
The inspection team consisted of three inspectors, this included a medicines inspector.

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

The home did not have a manager registered with CQC. The provider had a hands-on role at the home and had recently appointed a new manager. The manager told us it was their intention to make an application to register with CQC.

Notice of inspection
Inspection activity started on 2 July 2019 and ended on 10 July 2019. The inspection on 2 July was unannounced. On the 10 July, we returned to Hilgay care home, to review staff training records, this visit was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with seven members of staff including the provider, newly appointed manager, four care workers and the chef.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at six staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 Inadequate. At this inspection this key question has now remained the same, inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection people were at significant risk due to the ineffective assessment and management of both individual and fire risks to people. Medicines, care and treatment had not been provided in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made. This is the third consecutive inspection the provider has been in breach of regulation 12.

● The service did not always assess risk and ensure people who live at the service are safe, this included assessing risks of behaviours. Care plans had not been reviewed since March 2019 and did not always fully detail risks or give consistent guidance to staff. For example, a staff member said, four people required two staff when providing any form of personal care due to their "challenging" behaviours. Staff told us, there was a risk these people displayed episodes of verbal and physical aggression towards staff and made false accusations. The risks associated with these behaviours had not been planned and there was lack of guidance for staff to follow on how to support these behaviours.
● One person had a monitoring form to document the behaviours on an Antecedent-Behaviour-Consequence (ABC) Chart. This direct observation tool can be used to collect information about the events occurring for a person within an environment. "A" refers to the antecedent, or the event that precedes behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence. There was no evidence these records had been completed since March 2019. The person did not have a risk assessment or care plan to explain why this was in place. The impact of this means, the person's behaviour was not being regularly reviewed and analysed to ensure the support from staff was the most appropriate.
● People had been assessed as being at risk of skin damage and professional guidance had been provided to reduce this risk. This guidance was not fully reflected in people's care records. One person had a pressure relieving mattress. The mattress should be set according to the person's weight. Having the mattress set too firm or too soft could result in pressure damage occurring. There was no guidance in the person's care plan as to the correct setting. This increased the potential risk of skin damage to them. The failure to follow professional guidance increased the risk of harm to the person.
● Records did not demonstrate risks associated with hydration had been monitored to ensure people's safety. Fluid charts were completed for people who had been identified as being at risk from dehydration; however, we saw these were not completed in a timely manner, which increased the risk of error and inaccuracies.

● Medicines were not managed in line with regulatory requirements and best practice guidelines.
● Accurate records, for example, monitoring medication stocks, Medicine Administration Record (MAR) were not properly maintained. One person's medication had not been added to the MAR. Staff said they hadn't been using it. The person was breathless, which is what the medication was prescribed for. The staff member overseeing medication, added it to the MAR to administer. This was not double checked. This did not give a true record of medicines given to people.
● One person was prescribed a pain patch, there was no guidance of where the patch should be applied. Another person was prescribed a topical cream to be applied to their face and neck twice a day. MAR records indicated this not been applied on 20 occasions since 17 June 2019. The bath and shower records for 16 June 2019 stated the person's skin was sore. Another record made on 24 June 2019 described the persons skin as still sore and cream was still being applied. This gave conflicting evidence and there was no evidence of how this had been reviewed, or if the GP had been notified.
● Three people's records did not correctly identify their medication allergies, this did not protect people's safety.
● Medicines were stored in a locked room and items requiring cool storage were kept in a locked fridge. However, temperatures of the room and fridge were not always recorded. If the temperature is too high or too low, this could impact the effectiveness of medication.

People were at risk due to the ineffective assessment and management of individual risks to people. Medicines were not always provided for in a safe way. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider informed us, they would review people's care plans, medication records, prioritising who was most as risk, to ensure their needs were safely met.

● We found improvements had been made for people living with diabetes and who were at risk of choking. Although basic in completion, care plans provided sufficient guidance to staff in how to support them should they become unwell. Staff understood where people required support to reduce these assessed risks.
● Handover records sampled showed entries were completed by staff three times a day between 7 am and 8 pm. Handover records demonstrated that when staffing teams changed shift, people's needs were discussed such as their health and their mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs.
● Since the last inspection, there were fire safety plans in place to ensure people were evacuated safely in the event of an emergency. Equipment was tested regularly, including alarms and firefighting equipment. Personal emergency evacuation plans were in place which identified the level of support people would need if they had to be evacuated from the service.
● Monthly checks of the building and equipment safety were now completed. For example, in relation to water temperatures, window restrictors, bed rails, infection control and wheelchairs.
● Risks around the environment were managed well and there were external contractors who worked with the provider to ensure water, gas and electricity were all safe.
● All incidents and accidents were recorded by staff and reported to the provider and manager. The manager reviewed incidents and acted where required. For example, requesting input from outside professionals such as the falls prevention team. An analysis of accident and incidents from January to May 2019 had taken place to review any relevant learning to reduce the likelihood of repetition for people.

Staffing and recruitment

At our last inspection there were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection not enough improvement had been made. This is the third consecutive inspection the provider has been in breach of regulation 18.

● At our last inspection the provider had introduced a new dependency tool. This was not yet embedded in practice nor did it match the staffing levels we observed. This was a continued concern. The tool indicated to meet 11 people's needs, 40 hours of staff time was needed in a 24-hour period. The provider acknowledged this was incorrect and was providing additional hours, which the rotas reflected. The tool was not effective in determining the number of staff needed. This meant the provider could not be assured they had enough staff available at the times people needed to keep them safe.
● On day of our visit, there was one member of care staff allocated to work from 2pm to 5pm. This was to support 11 people, five of whom required assistance from two staff to provide their care safely. We brought this to the attention of the provider who acknowledged this was an oversight. A carer who had worked in the morning offered to remain on duty to support their colleague. The provider and manager helped with the share of care duties that afternoon. We have covered the provider's response, to this deficit, in well-led.
● On the first and second day of our visit, we identified further gaps on the rota, where there would not have been suitably qualified staff on shift to support moving and handling care or administer medication. The provider's solution to this competency shortfall, was to remain on site to administer medication for people and help carers on shift. This meant the provider was having to remain on site, at all times. We have covered this further in the 'well-led' key question.
● All staff felt low staffing levels affected the quality of care they provided. One told us, "There are three of us on right now, if two of us are supporting someone who is a double up, that leaves one staff member for the rest. How can we provide the quality of care a person should have?" Staff confirmed to us there were times when people were delayed in being able to have personal care as they required two staff to support them to move and there were not sufficient staff members working.
● People told us staffing levels did not meet their needs. One person said, "The staff don't have much time." Another person said, "I go downstairs and there is nobody (staff) there these days." Another person said, "There seems less staff to me. I just don't think they come around enough. If I rang this bell now somebody would come and see what I want. Sometimes I have to wait because they are fiddling with the supper downstairs. I've never really looked at the time, but it feels a long time. Sometimes they are so busy. It is lonely, very lonely, I would say."

The failure to deploy enough staff with the appropriate support training and professional development to care for people safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider informed us, they would prioritise which staff could be medication competency assessed within two weeks of our visit, to enable more flexibility of who could administer medication. The manager assured us, a new dependency tool would be sourced to reassess what staffing levels were required to provide a safe, high quality service. The manager withdrew the rotas and gave assurances they would be reviewed with immediate effect, to ensure there was enough suitably, qualified, competent staff deployed to meet people's needs. The manager arranged the use of agency staff cover some of these gaps to ensure people's needs could be met safely.

● People told us they felt safe. One person explained this was because, in their experience whenever they

pressed their call bell staff came to help them. We observed staff being responsive to people, however, staff told us, this resulted them feeling under pressure and stressed.
● The provider had followed correct procedures for safe staff recruitment. There were up to date documents on file such as, application forms, interviews notes, references and DBS (Disclosure and Barring Service) status confirmation. The DBS checks help employers make safer recruitment decisions and helps to prevent the employment of staff who may be unsuitable to work with people who use care services.

Systems and processes to safeguard people from the risk of abuse

At our last inspection people were not protected from abuse and improper treatment. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 13.

● The provider had effective safeguarding systems in place. Staff knew how to identify abuse and were aware of how to report it. Staff told us they were confident any concerns they raised would be acted upon.
● Safeguarding information was displayed in the service and leaflets were available for people to take away.
● Safeguarding incidents had been reported to the local authority.

Preventing and controlling infection
● Staff had completed infection control training and followed good infection control practices. They used protective clothing such as gloves and aprons during personal care, to help prevent the spread of healthcare related infections.

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 inadequate. At this inspection this key question remained the same, 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; Continuous learning and improving care

At our last inspection the provider had not ensured that they assessed, monitored or improved the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made. This is the fourth consecutive inspection the provider has been in breach of regulation 17.

- The provider's quality assurance systems were inadequate. Although there was a governance system and policies and procedures, the provider had failed to effectively implement these to support the continuous monitoring and improvement of the care provided.
- The provider had failed to identify areas of non-compliance with regulations in a timely way, to ensure prompt action was taken. Our findings throughout the inspection indicated there was a lack of adequate understanding of safe care and regulatory requirements including a lack of competence in the delivery of regulatory requirements in the home. The quality monitoring systems in place did not support the delivery of high-quality, person-centred care.
- We have continued concerns about the provider's leadership and management of the home. When concerns had been raised, the provider had, at times, not been receptive and had not recognised the level of risk people had been exposed to. There were continued concerns about the provider's oversight and ability to make improvements. Concerns found at previous inspections had not been sufficiently addressed or improved upon.
- The audit system lacked scrutiny. They stated staff were receiving training, supervision and care plans were being checked. They failed to demonstrate what was identified and what action was going to be taken and by when. When there were shortfalls they did not fully explore trends and patterns in relation to whether people were receiving medical care. Medicines and care plan audits had not been carried out regularly in line with best practice.
- There was a lack of oversight when people were at risk of dehydration. Staff were not always provided with accurate guidance about people's optimum daily fluid levels. When these had been provided, fluid intake charts showed people had sometimes not had sufficient quantities to drink. This had not been monitored nor appropriate action taken to ensure people's access to fluids was encouraged.
- Records to document the care people received were not well-maintained or completed in their entirety.

When people required support with their health condition, repositioning, fluid intake and weight to be monitored, records did not always document the care they had received. It was not evident if people had received appropriate care or if staff had failed to complete the required records.

● The provider had attempted to make some improvements in response to concerns that had been raised in relation to medicines management and risk. However, these were not robust and did not ensure risks were lessened and people received safe and appropriate care.

● The provider sought the views of people, relatives and staff through a recent quality assurance survey. The overall feedback was positive. In the staff surveys, staff had expressed concerns there was not always enough suitability trained and skilled staff available on every shift. They also shared management didn't clearly communicate to them. The were no assurances from the provider to demonstrate to staff how their feedback was going to be used, to improve this area.

● The provider had not ensured people's confidential records were securely stored when not in use. Care records and medication records were left in the communal area, this was observed throughout the inspection. This meant that people's confidential records cold be accessed by other people and visitors.

The lack of robust quality assurance and effective governance procedures meant people were still at risk of receiving poor quality care. The provider had not always lessened risks relating to the health, safety and welfare of people. Records were not always completed. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager informed us, they would review people's care plans, medication records, prioritising who was most as risk, to ensure their needs were safely met. The manager said, she would compile an improvement plan in response to the findings we shared at the time of this inspection and in response to the breaches of Regulation identified.

● The home did not have a registered manager. Since our last inspection there had been some management changes. The previous two deputy managers had left their employment and a new manager had been appointed. The new manager had been in post since 20 June 2019 and was planning to apply to register with us. The manager told us, they were committed to improving the quality and safety of the service and was in the process of devising action plans to implement changes to this end.

● The new manager had regular contact with the provider. They told us, they felt if the provider could step back, they would be able to make the changes needed. The manager had recognised they needed another manager to help with those changes, stating, "I have already advertised for a deputy manager and have interviews arranged."

● Staff and people spoke positively about the new manager. One staff member said, "We've got a new manager now and it seems to be getting better." Another staff member said, "I can see it improving with [new manager]. We had agency last night, she will get on the phone and arrange this. We're a family at the end of the day."

● Throughout our inspection the new manager was open and honest. They welcomed our inspection and feedback which they said would be used to focus and make improvements.

● The provider had met the legal requirements to display the services latest CQC ratings in the home and on their website.

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

● The provider's values of wellness, happiness and kindness were not always implemented in practice. Staff were observed sharing friendly interactions with people, respecting their choices, equality and diversity as well as their right to make decisions. However, the systems and processes within the home and the

provider's response to concerns in relation to people's care, did not always promote this practice.

● We informed the provider staff felt there were times when there were not enough staff working and how this had impacted staff wellbeing and people's experience of the quality of care received. The provider said, "I am always on site, so is the chef, and [new manager]. It isn't just them on shift, we are here to help, they just need to come and get us." One staff member said, "Now we've got [new manager] I can see things improving. She's really hands on. She's out there she's on the floor. Nothing's too much trouble. [Provider] needs to step back." The provider demonstrated a lack of understanding that staff did not feel they could communicate effectively with them. The provider did not understand that for staff to seek out other employed persons to help them with their tasks, this delayed their interactions with people and meant they were unable to always offer person centred, safe care.

● Staff told us the provider was not open to constructive feedback and felt there was a 'blame' culture within the home. For example, there were several recent medication errors reported. The reports emphasised who had made the errors rather than improving safety and sharing the learnings. Staff told us, that following our last inspection, the staff were asked to attend a team meeting and challenged why they had shared what they had with CQC. One staff member said, "[Provider] wanted to know who said what and why. She just doesn't get how bad it is or why we would have a problem."

● One person said, "They (staff) can't work with [Provider]. She is trying to do everything herself and alter things herself. The carers know far more than she does. Last night I had my medicine late, [Provider] was on night duty. They (staff) can't cope with the way [provider] is trying to run it."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were invited to share their views during residents' meetings. We saw that the menu and activities were regular features on the agenda. People told us that they felt able to speak with the provider. Some relatives had attended individual meetings with the provider, which were recorded. Suggestions from these meetings, such as for a person wanting different menu choices had been acted upon. Previous inspection reports had also been shared with people and relatives and their viewpoints encouraged on how the service could improve.

● The provider told us the home was developing close links and good working relationships with a variety of professionals to enable effective coordinated care for people. This included healthcare professionals, such as the advanced nurse practitioners and the local GP, as well as social care professionals such as the safeguarding and social work teams.

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 provider and service manager were aware of their responsibilities under the duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm.