Care Quality Commission

Freeways
Hillsborough House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service responsive?	**Requires improvement**

Overall summary

We carried out a comprehensive inspection of Hillsborough House in January 2015. Four breaches of the legal requirements were found at that time. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches. The breaches related to the management of medicines, staffing, care records and protecting people from abuse.

We undertook a focused inspection on 13 August 2015 to check the provider had followed their plan and to confirm they now met the legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'All reports' link for 'Hillsborough House' on our website at www.cqc.org.uk

Hillsborough House is a care home without nursing for up to 14 people with learning disabilities. There were 13 people living at the home at the time of our inspection.

The home was without a registered manager at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager was in post and this person had submitted an application to be registered with the Commission.

At our inspection on 13 August 2015 we found that the provider had taken action in order to meet the legal requirements.

Action had been taken to ensure people's medicines were being managed in a safe way. There had also been changes in the deployment of staff. As a result, people had more support from staff with their individual activities and staff were better able to ensure people were safe.

Summary of findings

People regularly talked to staff about their support and to discuss any changes that were needed. Improvements had been made to the care records so there was better information for staff about people's current needs and the changes that had been made.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

We found that action had been taken to meet the legal requirements.

There had been improvements in the way people's medicines were managed. The staffing arrangements had been reviewed and action taken to increase staff hours. This meant staff had more time to spend with people and risks to their safety were reduced.

The rating for this key question has changed from inadequate to requires improvement. We could not improve the rating for this key question from requires improvement; to do so would require a record of consistent good practice over time. We will review our rating for safe at the next planned comprehensive inspection.

Is the service responsive?

Requires improvement

We found that action had been taken to meet the legal requirements.

There was a more consistent approach to recording people's care and ensuring that information about people's needs was up to date.

Procedures had been improved so that staff were better informed about changes in people's care needs.

We could not improve the rating for this key question from requires improvement; to do so would require a record of consistent good practice over time. We will review our rating for responsive at the next planned comprehensive inspection.

Hillsborough House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Hillsborough House on 13 August 2015. The purpose of the inspection was to check whether the improvements planned by the provider after our inspection in January 2015 had been made.

This involved inspecting the service against two of the five questions we ask about services: is the service safe and is the service responsive. This was because the breaches found at the last inspection were in relation to these questions.

The inspection was unannounced and undertaken by one inspector. Before carrying out the inspection, we reviewed the information we held about the home. This included the report we received from the provider which set out the action they would take to meet the legal requirements. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with four people who lived at the home. We also spoke with two staff members and with the home's assistant manager (referred to as 'staff' throughout this report). The home's manager was available throughout the inspection. We looked at four people's care records, together with other records relating to their support and the running of the service. These included records relating to medicines and staff training.

Requires improvement

Is the service safe?

Our findings

When we inspected Hillsborough House in January 2015 we found that medicines were not always being managed in a safe way. In particular, there were shortcomings in the information that was available about people's prescribed medicines. This had been a breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 13 August 2015, we found the provider had taken the actions they planned to in order to meet this regulation. For example, records showed that the GP had been contacted for further information about people's medicines. One person's medicines had been reviewed and there was better information about the use of PRN ('as required') medicines. The provider's policy on medicines had also been reviewed. We saw examples of the current records of administration; these were up to date and showed people had received their medicines as prescribed.

Action had been taken to reduce the risk of errors arising involving people's medicines. This included introducing a new system of checks to ensure people received the correct medicines at the right time. We saw that people's medicines were being kept securely in their own rooms. People told us they liked this arrangement, which meant they received their medicines away from the shared areas of the home.

At the last inspection we found that some people did not always feel safe at the home. This was because of incidents which occurred relating to people's behaviour. Risk assessments in connection with such incidents had been undertaken. However they had not been reviewed to help ensure sufficient action was being taken to prevent incidents from happening. This had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection on 13 August 2015, we found the provider had taken the actions they planned to in order to meet this regulation. Risk assessments had been reviewed; changes had been made in the staffing arrangements to ensure people's needs were being met and staffing levels maintained at a safe level. New records for monitoring people's care had been introduced. This meant better information was available when the assessments were being reviewed.

Feedback from people at the home and from staff indicated that the number of incidents had reduced and people felt safer as a result. The staff meeting minutes showed that when incidents and significant events occurred, these were being discussed within the staff team. This helped to ensure staff were kept up to date with such events and had a consistent approach when providing support to people.

When we inspected the home in January 2015, we had found there were staff shortages which affected the support people received. There had been insufficient staff on duty; this had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 13 August 2015, we found the provider had taken a range of actions in order to meet this regulation. The deployment of staff had been reviewed; this was particularly to ensure staff were present to support people at times during the day when incidents were most likely to arise.

The home's manager confirmed the steps taken to increase staffing levels and the number of staff hours available. Additional support staff had been recruited. A cleaner had also been employed for 12 hours a week; this enabled the support staff to spend more time with people at the home. Additional 1:1 support hours for two people had been agreed with their placing authorities. Staff said these developments meant they were better able to support people with individual activities. They told us an increase in staffing numbers had helped to ensure a safe service was maintained for people. One staff member, for example, told us they had "More time for people".

The deployment of staff had also been reviewed in relation to people's needs at night. One waking staff member was currently deployed, with another 'sleeping in' to be available if needed. The manager told us they had considered the gender of staff who were deployed at night. This was to ensure staff were deployed in a way which met the needs of people who required personal care from a female member of staff.

Requires improvement

Is the service responsive?

Our findings

When we inspected Hillsborough House in January 2015 we found shortcomings in care planning and in how records were maintained. Information about people's care and the guidance available to staff was inconsistent. Staff had not always been aware of changes in people's needs.

This had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 13 August 2015, we found the provider had taken action to meet this regulation. Staff said that communication had improved within the home, which meant they felt better informed about changes in people's care needs. We were told that handovers and staff meetings were taking place regularly when staff shared information about people's care and welfare.

Records showed that most staff had received training in record keeping and the keyworker system since the last inspection. The manager told us that other staff were due to undertake this training. This helped to ensure staff were familiar with the care records being kept and knew to update these so there was good information about people's needs. The manager told us that support staff were to be allocated some additional time for administrative tasks to assist them with this.

Records showed that risk assessments and strategies relating to people's care had been reviewed since the last inspection. These included risks relating to moving and handling and epilepsy. Health professionals has also been involved to advise on the use of equipment and aids to meet people's individual needs.

People told us they talked to staff about their support and met with their keyworkers regularly to discuss any changes. 'Key worker' reports were produced which showed that people's health and wellbeing were reviewed with them on a monthly basis. The manager said procedures were now in place to ensure information was consistent between the key worker reports and people's care plans and other records. This was reflected in the records we saw. Changes in people's needs were also highlighted to staff at team meetings and recorded in the meeting minutes.

Staff said they thought people's care plans and other records gave a good picture of their current needs. The manager said they were auditing the care documentation on a regular basis to check it was being completed appropriately. The audits had not been documented so it was not possible to see the outcome. The manager said the audits would be recorded in the future. They told us some further improvements had been identified in relation to the records and these were being followed up with staff.