Mrs Jean Miles

Hillingdon House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hillingdon House is a residential care home providing personal care for up to 22 people aged 65 and over. At the time of our inspection, the service was supporting 19 people, some of whom were living with dementia. The home is established over three floors and a separate annex building next door with seven bedrooms and a small communal area.

People's experience of using this service and what we found

People did not always have the appropriate and correct equipment for staff to move them safely. People did not always have risk assessments and care plans in place that reflected their current needs. There was not always enough staff to meet people's needs. This placed people at risk of harm

The heating system was not fit for purpose. There was no external fire risk assessment in place. Infection Prevention and Control (IPC) guidance was not always followed to ensure people were supported to reduce the risk of exposure and transmission of COVID-19.

Staff did not always follow isolation guidance that was in place for the COVID-19 pandemic.

The covid-19 contingency plan was not effective and there was no one to run the home in the absence of the registered manager. There was no oversight of the home during the COVID-19 outbreak. People's care records were not reflective of current needs. The registered manager had audits in place. However, these were not always effective in identifying and addressing concerns.

Staff were aware of how and when to report abuse. People received their medication as prescribed. People told us they felt safe and were happy at Hillingdon House. Staff knew people well and had a good relationship with them.

People, staff and relatives told us they found the registered manager and provider approachable and they were encouraged to give feedback.

Rating at the last inspection
The last rating for this service was good (published 28 March 2019).

Why we inspected
We received concerns in relation to the management of medicines, infection control, and people's safety. We also received further concerns from the local authority whilst the home was having a COVID-19 outbreak.

Due to the COVID-19 outbreak, the registered manager required support from the local authority due to insufficient staff being available to support people. The local authority funded a consultancy company and the Care Home Intensive Support Team (CHIST) were deployed to support the home. These teams raised concerns including staffing levels, people's safety and the management and oversight of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. 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 changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this report.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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

We identified breaches in relation to people not receiving safe care and treatment and quality assurance systems not being completed to identify concerns and drive improvements.

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.

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

The service was not always safe

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Hillingdon 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

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

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

Notice of inspection
This gave the service five minutes notice of the inspection. This was because we needed to confirm the covid-19 status within the home and check what infection, prevention and control measures were in place.

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. 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.

During the inspection-
We spoke with four people who use the service and three relatives about their experience of care provided. We spoke with six care staff, the registered manager and the provider, the local authority, consultancy team that the local authority had funded and the Care Home Intensive Support Team (CHIST) that had been deployed to support the home. We will refer to these professionals as supporting professionals throughout the report.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Staff did not have clear guidance on how to support people with their mobility needs. For example, one person's care plan contained three different pieces of equipment to be used. Although staff we spoke with knew what to use and how to support this person, the information was not clear for new or agency staff. During the COVID-19 outbreak agency staff were being used. This placed people at risk of not receiving care in line with their mobility needs.

● People did not always have care plans and risk assessments which reflected their current needs. For example, one person had a 'summary care plan' in place, this care plan did not contain any information about the person's physical health needs or behaviours that may challenge, how to meet these needs and minimise the risks to the person despite being at Hillingdon House for three months.

Preventing and controlling infection

● Staff did not have clear and up to date guidance on how to support people to evacuate the building in the event of an emergency. This placed people at risk of harm in an emergency.

● Whilst staff understood government guidance around the use of personal protective equipment (PPE), they did not always follow this guidance. Support professionals found that there were breaches of PPE by staff when in the kitchen area. For example, staff were seen talking and putting their mask below their chin.

● The registered manager had increased the amount of cleaning within the home due to COVID-19 pandemic. However, during the home's COVID-19 outbreak, supporting professionals in the home advised that no cleaning, including frequently touched areas was not being completed as staff members did not have the time to do it and the domestic staff member was not at work. cleaning was not being completed as often as it should, including frequently touched areas.

● The Infection Prevention and Control (IPC) team visited the home to provide support and advice during the outbreak at the home. They highlighted concerns regarding infectious waste being in the incorrect bag and in bins without lids. This increased the risk of transmission of COVID-19. Whilst this had been corrected by supporting professionals in the home during the outbreak, we observed an infectious waste bin overflowing and staff required prompting to empty this.

Systems were either not in place or robust enough to demonstrate people's safety and risk were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did not always have the correct equipment in place to ensure they could be supported safely with their mobility needs. For example, one person was identified as having a sling that was too big for them.

● The home's heating system was not fit for purpose. We found that the hot water and heating was not in the annex building. We were informed that this happened regularly, and the boiler required resetting when this happened. In the main building, people's rooms were at inconsistent temperatures. For example, some people's rooms were warm, and the person told us they were comfortable, one person's radiator did not work, and two other people had their radiators turned off. The registered manager has since taken action to resolve this, and we have been informed all radiators are working and people's rooms are a more consistent temperature.
● The provider did not have an external fire risk assessment in place, this was set as an action by the local fire service in 2018. This placed people at risk of harm.

The premises and equipment were not consistently suitable for purpose and properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Supporting professionals highlighted staffing levels were not at a safe level to meet people's needs in a timely way. For example, one person was shouting out for support, the Care Home Intensive Support Team (CHIST) found them distressed having sunk down in their chair. Two staff members that were working were unable to support this person as they were already supporting someone else. This placed people at risk of harm and not having their needs met in a timely way.
● The local authority made the decision to fund a nurse to work in the home for one evening as the previous evening, three people had fallen, two within a short space of time. It was felt by the local authority that this was a result of staffing levels not being safe. As a result of insufficient staffing levels, a professional from the consultancy company was required to support one person who had fallen whilst another staff member called an ambulance.
● The CHIST highlighted that one day one of their support, without them being at the home to help and support people, people would have been at risk of significant harm as people's needs would not have been met in a timely way.
● The registered manager and provider agreed to increase staffing levels during the COVID-19 outbreak and agreed to re-assess when people had finished their isolation

Systems were not in place to ensure that staffing levels were safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite staffing levels not being consistently safe, staff had been recruited safely.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The registered manager completed a monthly audit for accidents and incidents to highlight lessons learnt and put actions in place. For example, one person who had been having recurring falls had been referred to the falls team for support. However, this was not consistent. Some of the audits completed by the registered manager had not identified the issues we did and therefore lessons had not been learnt.
● Feedback from other partner agencies reflected they found concerns regarding people's safety. However, people told us they felt safe when being supported by staff. When asked if they felt safe, one person said, "It's lovely here, yes".
●Staff demonstrated a good understanding of how to recognise and report abuse.

Using medicines safely

●Medication had not always been disposed of when it was no longer needed. For example, there was a large number of people's nutrition shakes that were no longer needed still at the home.

● At our last inspection we found that some people had missed their medication. At this inspection we found improvements had been made and people were receiving their medication as prescribed.

●Medication was stored securely, and people's medication administration records (MARs) were completed fully.

●Where people were prescribed 'as required' medication, we observed staff checking with people if they wanted this and completing the Medicine Administration Record (MARs) accordingly. There were instructions in place for staff on when to give this medication if the person was unable to communicate this to staff.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. 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;

●The provider had failed to ensure systems were in place to effectively monitor and assess the quality of the service in the absence of the registered manager. For example, the CHIST team identified that one person required their catheter to be changed. However, there was no stock for the district nurse team to do this. The registered manager advised us they would have usually ordered stock, but they were isolating due the COVID-19 outbreak in the home. This placed people at risk of not receiving care that met their needs. The registered manager has advised us they have started putting measures in place to ensure this does not happen again including delegating roles to other staff members and a stock sheet so that when they run low, this is identified and ordered.

● The registered manager, and provider, failed to have oversight and ensure all staff followed government COVID-19 isolation guidance. Whilst other partner agencies were providing support in the home, two members of staff and a close relative of the provider and registered manager arrived at the home who should have been isolating due to either testing positive or being a contact of someone who had tested positive. The registered manager told us they thought that one staff member had moved into the home for the outbreak. However, this was not the case and they were living with someone who had tested positive for COVID-19. The registered manager informed us they were unaware that another staff member and a close relative had arrived at the home.

● The registered manager had completed monthly reviews on people's care files. However, they had failed to identify where care plans and risk assessments contained conflicting information and information that no longer reflected the person's current needs. This placed people at risk of receiving inconsistent care from staff which did not meet their changing needs.

● The registered manager and provider did not ensure that their staffing levels were continuously safe. This placed people at risk of not receiving care in a timely and safe way.

● The registered manager's audits had not identified that the heating system was not in full working order meaning the temperature in people's rooms was inconsistent and at times the annex building was without both heating and hot water.

● The registered manager had not displayed their current rating in the entrance of the home or on their website. The registered manager informed us that the website had not been used for a long time and therefore had not been updated, they assured us this would be an action for them to complete. The registered manager explained their display in the entrance had recently been changed and they had forgotten to put their rating back up, they advised following the inspection this had been done.

Continuous learning and improving care

● The registered manager had completed audits to highlight issues that required actions. However, they did not always highlight concerns we and other partner agencies found. For example, their IPC audit had not identified issues with infectious waste being in open bins or in the incorrect bag. Their audits on people's mattresses failed to identify where people had a stained mattress and it needed replacing. The IPC team identified one mattress which was heavily stained, the registered manager replaced this. However, we looked at a sample of mattresses and found two out of five were stained and required replacing.

●The management team had failed to drive and sustain improvements and to ensure compliance with the regulations. At this inspection we identified four breaches in regulations.

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

The management team responded during and following the inspection to begin implementing an action plan of improvements required within the home.

Working in partnership with others

● Other partner agencies told us they felt the provider and registered manager did not work effectively with them due to not accepting support and not completing actions set. For example, the local fire service had set an action in 2018 for an external fire risk assessment to be completed, this action had not been completed.

● We saw from people's records that people had regular contact and input with services such as; GP, district nurses, local authority, dietician and mental health teams.

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

● Staff demonstrated an open and honest culture.

● There was a calm atmosphere within the home and staff knew people well and had developed a good relationship with people.

● People, relatives and staff spoke positively about the registered manager. One staff member said, "The management there is very supportive the working atmosphere is lovely, everyone works together to look after the residents."

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

●Staff were encouraged to be open and honest when things went wrong.

●Relatives were kept informed and updated. One relative told us, "We have regular emails and phone calls, anything that happens; we always know what's going on."

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

● Staff, people and relatives were encouraged to raise feedback. When feedback was raised, information was shared accordingly, and changes made. For example, changes to the menu following a residents meeting.

● Staff attended regular staff meetings and supervision. Meetings were used to encourage staff to raise any issues or concerns.

● As well as regular phone calls and emails, people were supported to make calls to their relatives during the pandemic.

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 12 HSCA RA Regulations 2014 Safe care and treatment The management team had failed to ensure that people had up to date care plans and risk assessments in place with clear guidance for staff on how meet their needs and manage any associated risks. Infection control guidance in relation to COVID-19 was not followed effectively to reduce people's risk of exposure and transmission of COVID-19.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The management team had failed to ensure people had correct and suitable equipment for staff to meet their mobility needs in a safe way. They had not identified that the heating system was not fit for purpose and they did not have an external fire risk assessment in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to ensure staffing levels were safe placing people at risk of not having their needs met in a safe and timely way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to ensure there were system in place to effectively monitor and assess the home in the absence of the registered manager. The registered manager's audits did not always highlight the concerns that we did. The management team did not ensure that staff adhered to government COVID-19 isolation guidance.

The enforcement action we took:

We issued a warning notice detailing our concerns to the provider. This set a requirement for the service to be complaint with the concerns we had raised by the 23 March 2021.