Freeways

Hillsborough House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We carried out an unannounced inspection of Hillsborough House on 28 and 29 January 2018. At the last inspection we found there were breaches of legal requirements for Care and Welfare Regulation 9. The provider said they would take action to address the concerns by 31 December 2014. However, we found at this inspection there was still a breach of this regulation.

Hillsborough House provides care and accommodation for up for 14 people with learning disabilities.

A registered manager was in post. 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.

People told us they felt safe and gave us examples on how this was achieved but the they felt "frightened" when other people used aggression and violence to show their frustrations. Staff told us their presence was not always

Summary of findings

possible to prevent incidents of physical abuse. People were not safeguarded from abuse or the risk of abuse because there were not enough staff available to provide the support people needed.

People were not protected from unsafe medicine systems. Parts of the property were dirty and fridge and freezers were not maintained at a safe temperature.

People told us the staff were kind and they knew how to care for them. The induction for new staff prepared them for the role they were to perform. Essential training ensured staff had the skills needed to meet people's need. Staff told us vocational qualifications and specific training to meet people's changing needs was not available to all staff because of limited places.

Mental Capacity Act 2005 (MCA) assessments were undertaken to assess people's capacity to make decisions about their accommodation and about leaving the property without staff supervision. Where people lacked capacity to make these decisions Deprivation of Liberty Safeguards (DOLS) were made to the supervisory body.

However, for some people the MCA assessments were not accurately completed. This meant the restrictions in place were not based on the person's ability to make decisions.

People participated in meal preparation and prepared their refreshments. We saw staff use a variety of approaches to encourage people to become independent. People told us their privacy was respected but we saw institutional practices. The regimes introduced to prevent inappropriate behaviours such as the misuse of bathroom toiletries were imposed on people. Individual strategies were not developed to prevent this behaviour from happening. This meant people's dignity was not respected.

Staff told us the manager was approachable and the staff worked well as a team. They told us there was a person centred approach to care which meant people were treated as individuals.

We found several breaches of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

This service was not safe. People told us they felt safe because they knew the people they shared the home with, the staff who cared for them and the security arrangements in place. However, they felt frightened when people expressed their frustrations in an aggressive and violent manner.

Staff were not always able to protect people from abuse. There were not always enough staff available at times when people were likely to become aggressive towards other.

Medicines were not managed safely and parts of the home were dirty. Fridge and freezers were not maintained at correct temperatures.

Is the service effective?

Requires Improvement

This service was not effective. Staff knew how to care for people. Staff told us the induction for new staff was good. They told us essential training was provided but vocational qualifications were not recognised by the organisation and specific training was limited.

Mental Capacity Act 2005 (MCA) assessments were completed for some people who required supervision at all times. MCA assessments were not consistent with the person's capacity and outcome decision.

People were supported by the staff to prepare their meals and refreshments. Staff were not always able to monitor the food and fluid intake of people at risk of malnutrition. This meant people were not supported to maintain a healthy weight.

Is the service caring?

Requires Improvement

This service was not caring. We saw there were institutional (regimes in place for long periods of times) practices which did not respect people's as individuals, their dignity or their confidentiality. The Activity board on display disclosed people's information about their activities . People were cared for as a group because of the regimes introduced to prevent inappropriate behaviour

People told us the staff cared for them well. We saw staff use a variety of approached to encourage people to be independent and to help them become calm. People told us their privacy was respected by the staff.

Is the service responsive?

Requires Improvement

This service was not responsive. Person centred plans and care plans were not up to date and action plans were not monitored to ensure people's needs were met.

Summary of findings

People told us they were involved in the development of their person centred plan. They told us meetings with their keyworker (designated member of staff) took place to review their plans. People told us they knew who to approach with their complaints.

Staff were not kept informed of people's changing needs. They told us care plans and reviews of needs were not always read and handovers when shift changes occurred were not detailed. Person centred plans and care plans were not up to date and action plans were not monitored to ensue people's needs were met.

People told us activities happened in the community and with their keyworker. They told us time with their keyworker also took place but it was often cancelled.

Is the service well-led?

Requires Improvement

This service was not well led. Audits of medicine errors, complaints and safeguarding referrals in place showed the reasons for referral and nature of complaints. However, preventative measures were not part of the audit. This meant audits were not used for staff learning and for meeting people's changing needs. Staff told us information about the organisation needed to improve.

People told us monthly house meeting were organised to seek their suggestions about holiday venues and activities.

A registered manager in day to day control of the home was in post and staff told us this manager was approachable.

The provider assessed the standards of quality and action plans were developed where standards were not fully met.

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. 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.

This inspection took place on 28 and 29 January 2015 and was unannounced. It was carried out by an inspector.

Before the inspection we spoke to and looked at information from Local Authority Commissioners of the service and previous inspection reports and notifications. Services tell us about important events relating to the care they provide using a notification.

During the inspection we spoke with two people and observed the way staff interacted with people. The registered manager was not present during this inspection; we spoke staff, the nominated individual and the Head of Care and Support. We reviewed records including the care records of six people, policies and procedures, schedules and monitoring charts, audits of systems, reports of accidents.

Inadequate

Is the service safe?

Our findings

People told us the staff administered their medicines. The administration of medicines was part of the staff's role and a team leader had responsibilities for the ordering of medicines and for stock control. A communication sheet was included in the medicine file which informed staff of changes of directions and wasted medicines. Individual profiles had a photograph of the person which ensured the staff administering the medicines were able identify the person. Within the individual profile were the person's medical condition and the preferred method of taking the medicines. Medicines Administration Records (MAR) charts were signed to show the medicines administered. Where medicines were not administered codes where used to give the reasons for not administering the medicine.

People were not protected from the risk of unsafe medicine administrations. The directions for administering medicines were not easily accessible to staff as for some people this information was missing from the MAR charts and medicine packets. We saw the MAR chart for one person did not include the directions for administering medicines prescribed to control epilepsy. The directions were also missing from the packet. The staff told us the directions were included in the communication sheet but we were not able to find the directions for administering this medicine.

People were prescribed with medicines to be taken "when required" (PRN). "When required" medicines were not documented on the MAR charts for some people who were prescribed with these medicines. "When required" medicines were not always documented in the current MAR chart and clear instructions were not included in the MAR charts for when these medicines were to be administered. The Medicine Administration procedure says "PRN medication is only to be used following clear instructions and documentation from the relevant health care professional. This information is to be kept in the medication file and a copy to be kept in a resident's personal file". This meant people were not protected against the risk of unsafe administration of medicines. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from the spread of infection because communal areas such as stairs and corridor as well as the medicine cabinet was dirty. Stairs had excessive dust, marks on the walls and the carpet. The medicine cabinet and stock (disused) fridge were dirty with a sticky substance from spilt liquid medicines and debris. A member of staff we spoke with told us there were no cleaning schedules for communal areas. They told us agreements on schedules were not reached with the staff. People told us they were supported during their time with their keyworker to keep their rooms clean.

Fridges and freezers were not kept at safe temperatures. We saw on display on the front of the fridge the safe temperature range. The recommended safe range was between 5 and 8 degrees. On the previous inspection carried out on 12 August 2014 we observed that the temperatures recorded were high. We were provided with information which confirmed the matter had been addressed and the fridges had been checked. The evidence stated the "thermometers were faulty and not the fridges." On this inspection the recorded temperature checks between 28 December 2014 and 28 January 2015 showed the fridge temperatures were often below 5 degrees. The records for fridge two were often minus 3 degrees. This meant people were at increased risk of food poisoning because the fridges and freezers were not functioning within the legal limit of 8 degrees. Following this inspection we were provided with information about the fridge and freezers being replaced.

People told us there were times when other people expressed their frustrations using aggression or violence. They said "sometimes people get angry with each other and staff say 'don't get angry.' Sometimes I get anxious when people hit each other." Another person said "sometimes people get angry with each other. The staff stop them from hitting us." We saw people had complained about physical and emotional abuse from other people. For example, in one care record we saw an "unhappy" (complaint) form completed by one person because they became "upset" when another person was shouting. We saw there were discussions with the people involved and where appropriate social and health care professional were contacted. However, risk assessments were not reviewed to ensure the guidance to staff prevented reoccurrences of the incidents.

An overarching risk assessment was devised to manage "flash points" (times during the day when people were likely to become aggressive) for example, meal times. The actions plan stated that a member of staff was to be

Is the service safe?

present in the lounge to help people remain calm during these “flash points”. However, on the first day of the inspection there was no staff presence in the lounge at tea-time. Staff told us there were staff shortages and at times staff presence was not possible in the lounge during peak periods. One member of staff said “The main trigger is tea-time. One member of staff is usually cooking, another administering medicine and one staff ideally sat in the lounge. When there is support (staff) challenging incidents are avoided. It doesn’t work because we are short staffed. Often there are only two staff on duty at tea-time when three (staff) should be on duty.”

The comments made by the staff showed they had a good understanding of assessing risk to ensure where risks were identified people's safety were maintained. Staff told us where risks to people’s safety were identified, risk assessments were developed. For example moving and handling and managing difficult behaviours. We were told keyworkers (with designated responsibility for specific people) reviewed the risk assessments monthly to ensure they reduced the level of risk to the person and to others. Staff told us following an incident or an accident, Occasion Reports were completed. They told us occasion reports were then passed to the manager for evaluation. A member of staff said “incident where there has been physical abuse, there is an occasion report. The build-up of the incident is detailed in the report. The manager will then read the report. We looked at a range of occasion reports. Although, the manager had signed them and listed the social and health care professionals contacted about the incident or accident the strategies and risk assessments were not reviewed. The potential of these events reoccurring were not assessed and increased the possibility of the event reoccurring. This meant people were not safeguarded from abuse or the risk of abuse. This is a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us their one to one time with their keyworker was often cancelled. One person said “a lot of things get cancelled, today my one to one time was cancelled and I will be watching the television.” This person said recruitment for more male staff was in progress. We were told the male staff were going to offer more choice for personal care to male residents. The staff we spoke with said there were staff shortages. One member of staff said “there is not enough staff. Housekeeping staff left and activities are not taking place because we have to do the cleaning.” Another member of staff said “there is not enough staff. We don’t get told a lot. A lot of staff leave.” The nominated individual (provider) and assistant manager told us recruitment for more staff was in progress. This meant people’s health and welfare needs were not met in a timely manner. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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We looked at a range of occasion reports. Although, the manager had signed them and listed the social and health care professionals contacted about the incident or accident the strategies and risk assessments were not reviewed. This meant the potential of these events reoccurring were not assessed.

Requires Improvement

Is the service effective?

Our findings

People told us the staff knew how to meet their needs. Staff told us an induction was provided to all new staff but there was little opportunities for professional development. One member of staff said “during induction the training is good and intense. Time is spent going through the standards then it ends. There is training I would like to do, like dementia because we have people living with dementia. You just don’t hear about it [training]. You don't go on NVQ (National Vocational Qualification) ” Another member of staff said “Freeways training is good but vocational qualifications are not recognised. It would be nice to have more training.”The Head of Care and support told us there were limited spaces for dementia awareness training and it was to be arranged. The training matrix in place showed staff had attended the organisation’s essential training which included safeguarding adults, Mental Capacity Act 2005 and moving and handling.

Staff said there were regular one to one meetings (supervision) with the registered manager to discuss performance and concerns. One member of staff said "sometimes action there are actions set from the one to one meeting plan but there are not always followed -up." Although staff said they were supported they said information was poor. They said "we don't get told a lot."

People told us the types of decisions they made and who helped them make more difficult decisions. One person said “staff help with more difficult decisions like medical treatment. You can say no sometimes but usually I say yes.” Staff knew their role involved enabling people to make decisions. They told us they had attended MCA training. One member of staff told us they had supported people who lacked capacity to understand their medical treatment. Another said “People are given choice and time to reach a decision.” A third member of staff said “we break it down [information] into simple sentences and we show people the options available.

People told us they were always accompanied by staff when they left the property. They told us the front door was always locked and alarmed to alert staff when the door was opened. Staff told us one person was not safe in the community and this was the reason the door was alarmed. They told us with the exception of one, people were always accompanied by staff in the community. Mental Capacity Act (MCA) assessments were undertaken to assess people’s capacity to make decisions about their accommodation and leaving the building independently. However, the findings were not accurately reflected. For example, an MCA assessment we looked at had determined one person had capacity to make decisions but it was recorded the person was not safe in the community and had to be accompanied by staff because they were not able to safely cross roads.

Mental Capacity Act 2005 (MCA) assessments were not always undertaken to determine people’s capacity to make specific decisions such as medicines for anxiety to be administered before appointments. We saw one person was prescribed with medicine to be administered before medical appointments but an MCA assessment was not undertaken to assess the person's capacity to make decision. Where the person was then found to lack capacity there was no evidence the decision was in the person's best interest. This meant capacity assessments were not appropriately completed and best interest decision were taken for people who lacked capacity. .

We were told Deprivation of Liberty Safeguards (DoLS) applications were made to the supervisory body for people who were subject to continuous supervision and lacked the option to leave the home without staff supervision. DoL’s provide a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

People told us they were involved in preparing their meals. One person said “meals are ok. People decide what they eat. Those that are able help the staff.” Another person said “We get nice food and we choose our own meals. We make it”. We saw people making meals and refreshments at variable times during the day.

Staff told us the arrangements for people who were at risk of malnutrition. We were told people were weighed on a monthly basis to monitor that a healthy weight was maintained. A member of staff told us dietary supplements had been prescribed for people at risk of malnutrition and thickeners in drinks for people at risk of choking. Another member of staff told us the intake of food and fluid was monitored for people who were not maintaining their weight. We were told snacks were offered between meals but as people prepared their meals on busy days they were

Requires Improvement

Is the service effective?

not always able to monitor the food and fluid intake of people. Food diaries were not consistently completed and on occasions staff had recorded "?" and "not witnessed" the person prepare or eat the meal. The keyworker monthly report for one person stated they were losing weight and an action plan was developed which included regular meals and snacks to be served between meals.

People told us they had a GP and had regular check-ups with the dentist. One person said "yes I see the doctor and the dentist every six months." Staff told us people had annual health checks with a specialist GP or nurse. Health action plans were then developed from the health check to help the person be healthy. Visits to healthcare professionals with their advise was documented in the health action plans. When people had health care needs a plan of action was not devised. For example mental health care needs or dental care.

Hospital Passports which included important and essential information about the person in the event of a hospital admission. This passport ensures medical staff have the information needed to care for the person.

Requires Improvement

Is the service caring?

Our findings

We saw an activities board on display in the dining room which included the names of the people living in the home and their daily activity. One member of staff was not aware of the decisions made to display people's information. Another member of staff said the information was used for quick reference and "I don't think people would worry, people like to know." A third member of staff told us having an activities board on display was "institutional" (long standing regimes imposed on groups of people) This meant people were not respected as an individual and their confidentiality was not respected.

People did not have access to bathroom tissue in all the toilets. Staff told us bathroom tissue was kept locked due to one person's behaviour which at times caused blockages of the toilets. A comment made by a member of staff about people's hygiene was inappropriate and showed people's dignity was not respected. Another member of staff recognised the importance of ensuring people were cared for as individuals and not as a group. However, less institutional options which gave other people access to bathroom tissue was not considered by the staff. The nominated individual and the Head of Care and Support were not aware of this practice. This meant people had restrictions imposed on them because of one person's behaviour.

People told us they felt respected by the staff. One person said "Yes sometimes I feel respected but not when other people enter my room without knocking." Another person told us "I have a key to lock my bedroom door. The staff close the door when I have a bath. My parents visit and we sit in my bedroom." Members of staff gave us examples to describe the way people's privacy was respected.

People told us they liked the staff. During our visits we saw the staff used a variety of approaches to encourage people to be independent. For example, to prepare their meals and refreshments. Staff used humour to encourage some people and for others detailed explanations were used. People approached the staff for support and the staff stopped their activity and listened to what the person was asking. We saw staff discuss with people their day's activities and who was to support them. On the second day of our visit we saw people having one to one time with their keyworker (designated member of staff).

Requires Improvement

Is the service responsive?

Our findings

On the previous inspection which we carried out on 12 August 2014, we reported that care plans were inconsistent. We found care plans were not up to date and did not have sufficient information to provide guidance to staff about the care and support people needed. We saw no improvements in care planning since this inspection.

Person centred care plans were in place for some people but they were not updated following the annual reviews. Staff said there were care plans for people with daily living needs, such as personal care, health care and difficult behaviours were devised. They said the keyworker role included reviewing people's care needs monthly which covered the person's health and wellbeing as well as setting goals. A keyworker pack was developed monthly but care plans and person centred plans did not reflect the changes from the keyworker pack. Care plans were not devised for each area of need. For example health action plans referred staff to strategies to support one person with mental health care needs but a care plan was not in place. Where care plans were in place they were not reviewed to ensure the action plan was appropriate to meet people's needs.

Members of staff were not aware of people's changing needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. We saw keyworkers had documented in the keyworker packs changes in people's care needs including health advice. For example dental care, managing deterioration of mental health and behaviours others found difficult to manage. However, there was no evidence that this advice was followed by the staff. For example, advise from the healthcare professional to support a person with oral hygiene to prevent decay was reinforced in the keyworker pack but there was no record of this advice being followed. The staff told us they did not read care plans and only read the keyworker pack for specific people. They told us daily handovers did not provide them with information about people's changing needs. Staff made the following comments about handovers "depends on who is giving the information. It depends on what staff think is important" and "some give more information than others. The best account should be given but there is not enough detail."

People with moving and handling needs were living at the home and equipment was used to support them with some transfers. For example from bed to wheelchairs. Risk associated with moving and handling equipment were not assessed. This meant people were at potential risk of unsafe care and treatment.

People told us they had the attention they needed from staff and their care was provided the way they liked. One person said "yes the staff are nice and they know how to care for us. I have a person centred plan and we have meetings about it." A member of staff said person centred plans were based on what was important to the person and setting of goals. An action plan was then devised to help the person achieve their goals.

People told us the arrangements for activities. One person said "go out for horse riding, walks, nice room and tidy room with xx." Another person told us they had community based activities and one to one time with their keyworker (designated member of staff). People told us they had a keyworker who helped them keep their bedrooms tidy, accompanied them on shopping trips and arranged for one to one time. There was also an expectation each person prepare their meals and clean their rooms. Staff said people were encouraged to prepare their lunch and to help with the tea-time meal.

People told us they knew who to approach with complaints or concerns. One person said "go to the keyworker or manager but I don't have one." Another person said they went to the staff with complaints. Staff told us complaints were seen as feedback and an opportunity to improve services for people. Another member of staff told us when people approached them with complaints they helped the person to complete "unhappy" forms. Staff told us "we don't know if anything happens from them." We saw completed "unhappy" forms in care records. We saw discussing the incident with the person was the only action taken to resolve the complaint.

Requires Improvement

Is the service well-led?

Our findings

People told us their feedback about the running of the home and group activities were sought. We were told at monthly meetings they were asked to make suggestions about holiday venues and activities.

Staff told us meetings took place monthly and minutes of the meetings kept them informed about any agreements reached and policy changes. Another member of staff told us there was a lack of information and we were told “top down” information sharing needs improving. We were told there was a lack of communication from the provider which staff said needed to improve. A member of staff said "we need to know what we are doing, how to do it better and help us with better ways of working."

Staff said the manager was approachable. This manager has been in post and registered with the Care Quality Commission since 2013. 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.

Staff said the “team worked well. We support people to live independently. Care is provided in a dignified manner.” Another said “try to have a happy home. Most [people] have known each other all their lives. Give people choice. It’s all person centred. All about the person. What they want to do and staff try and do it.”

The provider monitored the quality of the service. The provision of care and treatment was assessed by the Head of Care and Support with the manager at the twice monthly meetings. Where standards were not met action plans were devised and ongoing action plans were reviewed.

A system of audits was used to assess the standards of care and treatment. We were provided with copies audits for medicine errors, safeguarding referrals and complaints. The audits of the safeguarding referrals and complaints included the reasons for the referral or the nature of the complaint but the preventative action to be taken was not included. For example, we saw seven complaints were made about physical abuse from one person towards another person. The action taken to prevent any further reoccurrence was not part of the action to conclude the complaint.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not safeguarded from abuse or the risk of abuse because reasonable steps were not taken to identify the possibility of abuse and prevent if before it occurs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People's health and welfare needs were not met in a timely manner because sufficient numbers of staff were not on duty at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risk of unsafe administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare