Hillcrest Community Ltd

Hillcrest COMMUNITY

Inspection report

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09 February 2021
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12 February 2021

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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
Hillcrest Community is a domiciliary care service based in Leeds, providing personal care to 23 people at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Consent to care forms were not always in place and mental capacity assessments (MCA) were not carried out when needed. Medicines were not managed safely, people did not always receive their medicines in the way prescribed for them. Risk assessments were not in place for people's health conditions nor were COVID-19 risk assessments.

The provider failed to ensure safeguarding records were in place, however the provider ensured this was actioned during the inspection. Safeguarding referrals were not always being made for necessary incidents. Various areas of training including safeguarding training was not up to date for all staff members. Staff and people we spoke with told us they did not feel moving and handling practices were safe. Some training had been scheduled since the inspection.

Staff and people told us they felt the service did not have enough staff. One staff member told us, "I was really poorly yesterday and she [the manager] made me feel guilty, the manager said to me yesterday how I am supposed to cover your shift. I have been doing 16 or 18 calls a day you still get extra calls, two days ago I didn't get a break. They don't ask you they just give you extra calls." Another staff member said "When we are short staffed we get extra calls and pressured and made to feel guilty to come in on our days off. I get phone calls a lot and rota changes all the time."

At the time of the inspection the provider had not completed the correct paperwork to notify CQC they had moved location. The service was not displaying their current CQC rating, which was a legal requirement. The provider's statement of purpose did not accurately reflect the current registration details of the managers within the service, as the service did not have a registered manager.

Care plans were not always in place and did not accurately reflect peoples care needs or health conditions. The provider and manager were working on creating and updating care plans where needed. The provider had no feedback, oversight and audit processes in place. The provider had no necessary records, reviews or actions in relation to accidents and incidents, this was put in place after our site visit. Lessons learned were not taking place when things went wrong.

Policies were not dated or signed, so we were unable to know if these had been read or when these were

due for review. Their infection control policy (IPC) had not been updated since the COVID-19 pandemic. The service were providing staff with appropriate personal protective equipment. Staff supervisions were not taking place in line with the provider's policy. Necessary background checks were not always in place when recruiting staff. Staff told us they enjoyed caring for people.

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

Rating at last inspection
The last rating for this service was good (published 20 December 2019).

Why we inspected
We received various concerns in relation to this service. 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 inadequate. This is based on the findings at this inspection. We have found evidence the provider needs to make improvement. Please see the safe and well-led sections of this report. You can see what action we have told the provider to take at the end of this report.

The provider has taken actions to mitigate some of the above risks, but it is too soon to know if these have been effective.

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

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 have identified breaches in relation to consent, safe care and treatment, safeguarding, good governance and employment of fit and proper people at this inspection.

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.

Special Measures
The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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.

Hillcrest COMMUNITY

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 was carried out by an inspector and a pharmacy inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses.

The service did not have a manager registered with the Care Quality Commission. This meant the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 9 February 2021 and ended on 12 February 2021. We visited the office location on 9 February 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we used this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including the nominated individual, the manager, and care workers. The nominated individual was responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and six medication records. We

looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- People were not always safeguarded from risk of abuse.
- Referrals in response to safeguarding events were not always made. The provider or manager was unable to provide any referral information.
- Not all staff had completed safeguarding training, however, most staff were able to explain what they would report as a safeguarding concern.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safeguarding concerns were effectively managed. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider had scheduled safeguarding training for all to staff to ensure they were up to date. We spoke with the safeguarding lead form the local authority and we were told they were in regular contact with the service.

Staffing and recruitment
- Robust systems and processes were not in place when the service recruited staff. Safe recruitment procedures had not always been followed with the necessary checks and documents not always in place.
- One staff member had been completing calls independently before their necessary recruitment checks with the disclosure and baring service had been completed.

We found no evidence that people had been harmed, however, systems were not robust enough to demonstrate safe recruitment procedures were being followed. This placed people at risk of harm. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and staff told us they did not think the service had enough staff. One staff member told us, "There is not enough staff no." One person said, "They [the management] promise you a lot, but there is a lot of times they can't fulfil promises, they don't have enough staff."
- Some staff told us they did not have enough time to get to calls. We reviewed a sample of staffing rotas and found travel time wasn't always built in-between calls. This was an issue raised at our last inspection. One staff member said, "Sometimes you get five minutes, sometimes you don't, but it's not enough."
- There was no mechanism in place to monitor or record if missed calls had happened. Some people told us

they had experienced missed and late calls. One person told us, "Yes, I have late and missed calls, but no missed calls recently."

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

● Consent to care forms were not always in place and mental capacity assessments were not completed when necessary.
● We reviewed two care plans for people living with dementia. Neither of these people had their capacity assessed.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate peoples consent or capacity was being considered. This placed people at risk of harm. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks were not always appropriately assessed.
● Both people and staff expressed concerns around the training and use of moving and handling equipment. One person told us, "One particular carer, she put me the wrong way in a hoist and I banged my hip against a set of drawers. When she finally got the right way, she scraped my bottom against the bed rails." Another person said, "They can't use my hoist they don't know how to." One staff member said, "[Person's name] needs showering but I don't know how to use the hoist so we can't." Another staff member said, "I use a hoist and sling for some service users, but I haven't had any training."
● Records showed 14 out of 16 staff had completed e-learning moving and handling training, but not practical training. Since our site visit the provider has arranged further moving and handling training for staff.
● Medicines were not managed safely. Medicines Administration Records (MARs) had signatures missing to show medicines were given. They did not contain all the information required for staff to administer medicines safely. When changes were made to MARs, there were no signatures of who made the amendments.
● Three people's MARs had been signed to say medicines had been administered when they hadn't.
● One person told us their medicine was being left out for them to take as staff did not always attend for the evening call. No risk assessment for this had been completed. Staff had been signing the MAR as if it had been administered.
● Records showed some people had missed doses of their medicines, as there had not been an adequate interval between call times.
● Some people did not receive their pain patches as prescribed. They were changed later than they should have been. One person told us, "I don't get them on time. They are supposed to put them on every 72 hours, and I can't count how many times they haven't done it. One time they [staff] missed a whole cycle. I was left in pain."
● There were no medicines audits available and no record of medicines incidents including those mentioned above.

Systems were either not in place or robust enough to demonstrate safety was 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.

The procedure for producing MARs is currently being reviewed and the provider had made some improvements in this area.

● Lessons learned were not taking place. The provider was not able to provide any examples of any lessons learned the service had undertaken after safeguarding incidents, medication errors, complaints and accidents and incidents.
● Five people told us they felt safe whilst two told us they did not. People's comments includes, "Yes (the care received is safe), the ladies are all very pleasant" and "No (the care received is not safe), because some of the carers don't know how to use a hoist properly."

Preventing and controlling infection
● The provider's infection control policy (IPC) was not up to date. It had not been dated, reviewed or signed and had not been updated since the COVID-19 pandemic. This was feedback to the provider.
● We were assured the provider was providing appropriate personal protective equipment to staff.
● The provider was accessing testing for staff.

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 good. At this inspection this key question has now deteriorated to 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; 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 was not meeting their regulatory requirements and had not been monitoring risk or performance. We asked to see a variety of audits, but the provider was unable to provide these.
- CQC were not appropriately notified when the registered address changed.
- The provider was not displaying their current CQC rating in the service.
- Policies were in place but were not dated or signed, so we did not know if these had been read or when they were due to be reviewed. Their IPC policy had not been updated since the start of the COVID-19 pandemic.
- Staff supervisions were not taking place in line with the provider's policy.
- Three people did not have care plans in place to direct staff on how to support them. Though two were relatively new to the service, care plans should be in place to support staff to meet people's needs. Following our inspection, the provider was working on creating care plans for those which were missing.
- Care plans did not accurately reflect peoples care needs or health conditions. One person had a single health conditions listed in their care plan, however, their prescribed medication indicated they also had various other conditions. This was confirmed with the manager.
- The provider failed to ensure accidents and incidents were being recorded, reviewed and actioned.
- As mentioned in the safe domain, the service was not completing lessons learned from previous incidents.

- Five of the six care plan we reviewed did not have consent to care forms in place.
- Hillcrest Community's statement of purpose was inaccurate and did not reflect the current CQC registration status of the managers of the service. This document stated the service had two registered managers with CQC, however, this was not the case.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate records and governance was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst onsite the manager ensured the rating was displayed. Since the inspection, the provider advised that a log had been created to record incidents.

● The provider had not sent any statutory notifications to CQC since registering with the commission, which is a legal requirement. We were made aware of five instances the service should have notified CQC of, but they had failed to do so.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate incidents were effectively managed. This placed people at risk of harm. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● The service did not have a registered manager in post. The previous registered manager de-registered in January 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People using the service did not always receive good outcomes as identified in the safe and well led domains.
● Although staff told us they enjoyed their roles, feedback about management and leadership was mixed. Some staff told us they felt supported, however, this was not consistent throughout the staff team.
● Staff did not always feel that people using the service received good outcomes. For example one staff member told us, "I don't think the service are responsive enough."
● People were not given the opportunity to provide feedback to help drive improvement within the service.
● People felt the service was not always well managed. One person told us, "They [the provider] are unprofessional and ill managed." Another person said, "It has its ups and downs."
● The service worked in partnership with the local authority and health teams.

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
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not sent any statutory notifications to CQC when regulations deemed them necessary.

The enforcement action we took:

We took enforcement action but this did not proceed as the service was re-inspected and improvements were found.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not always completing consent to care forms and were not always ensuring MCA assessments were taking place when they were needed.

The enforcement action we took:

We took enforcement action but this did not proceed as the service was re-inspected and improvements were found.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication was not always being administered safely and was not being managed and monitored appropriately. Medicines records and training were not always up to date.

The enforcement action we took:

We took enforcement action but this did not proceed as the service was re-inspected and improvements were found.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Safeguarding referrals were not being made. The service were not keeping a record of any referrals that had been made. Safeguarding training was not up to date for some staff.

The enforcement action we took:

We took enforcement action but this did not proceed as the service was re-inspected and improvements were found.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was operating from an unregistered address and the CQC rating was not being displayed. Audits were not taking place. Policies were not dated or signed. Care plans did not accurately reflect peoples care needs. Staff supervisions were not taking place in line with policy. No accident and incident logs were in place No lessons learned were taking place. Necessary notifications were not being made. The providers statement of purpose was not accurate.

The enforcement action we took:

We took enforcement action but this did not proceed as the service was re-inspected and improvements were found.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment was not robust meaning that safe recruitment procedures had not always been followed. Necessary checks were not always in place.

The enforcement action we took:

We took enforcement action but this did not proceed as the service was re-inspected and improvements were found.