Mayflower Care Homes Limited

Hillgrove Residential Home

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
Hillgrove Residential Home is a residential care home owned and managed by the provider Mayflower Care Homes Limited. It is registered to provide accommodation and personal care to up to 23 people. At the time of this inspection there were 19 people living at the home.

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

The systems in place to monitor the quality and safety of the service were not effective. Audits were not in place for all aspects of the service, they were not completed regularly and did not identify the risks that we highlighted during the inspection. Systems were not in place to gather regular feedback from staff, people or their relatives, regarding the service, to enable changes and improvements to be made as necessary.

Although risk assessments and care plans were in place, risks to people had not always been assessed or mitigated to maximise people's safety, such as those relating to COVID-19, falls and fire safety.

Medicines were not always managed safely. Protocols were not in place for all medicines prescribed 'as and when required' and stock balance checks were not all accurate. Staff had undertaken medicine training, but records of competency assessments were not available for all staff who administered medicines.

Appropriate infection prevention and control measures were not all in place to prevent the spread of infection. Not all areas of the home had been thoroughly cleaned and although cleaning schedules were in place, they did not cover all areas of the home. Staff told us they completed regular tests for COVID-19, however records did not support this. Staff had undertaken infection control training and had access to appropriate PPE.

Staff recruitment records showed that all staff had a disclosure barring check prior to commencing in post, however, not all other safe recruitment practices were adhered to. We made a recommendation about this in the main body of the report.

People's relatives told us they felt their family members were safe at Hillgrove and feedback regarding care provided was positive. There were enough staff to meet people's needs in a timely way and staff were aware of how to raise any safeguarding concerns they had. Relatives told us they were kept informed of any changes regarding their family member and had been able to have contact with them during the COVID-19 pandemic.

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 February 2019).

At our last inspection we recommended that the provider ensured the rating of the service was displayed on their website as required. At this inspection, we found that this had been actioned.

Why we inspected
The inspection was prompted in part due to concerns received about infection prevention and control and staffing issues. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the infection prevention and control measures in place, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to infection prevention and control, management of medicines, risk management and the governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Hillgrove Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was undertaken by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Hillgrove Residential Home 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
On the first day we gave four hours' notice of the targeted inspection. The second day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with the manager and three members of the staff team. We contacted the relatives of eight people who lived in the home over the telephone, to gain their feedback and experiences.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to safe recruitment. A variety of records relating to the management of the service, including audits were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found during the visit and that sent electronically following the visit.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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

- Risks to people had not always been assessed or mitigated to maximise people's safety. For example, there was no evidence that people's risk in relation to COVID-19 had been assessed or mitigated. One person had been assessed as at high risk of falls, but there were no actions recorded to enable staff to minimise that risk.
- Fire safety had not been robustly assessed. Not all staff had completed fire safety training recently; there was no record of fire drills available for day staff and a fire risk assessment for the home was not available. After the inspection, the manager sent a new self-assessed fire risk assessment, however there was no evidence to establish if the person who completed it was competent to carry out the assessment.
- Internal and external checks were not completed regularly to help ensure the safety of the building. For example, emergency lighting checks had not been completed since August 2021 and there was no evidence that actions had been taken to reduce the risk from legionella, such as cleaning of shower heads.
- We also found that weekly fire alarm checks had not been consistently maintained, with records showing months between checks at times.

Failure to ensure risk is appropriately assessed and mitigated is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not always managed safely. They were stored securely in a locked trolley in the lounge; however, the temperature of the room was not monitored daily as required. When it was monitored, it was within the recommended temperature range.
- There was not always enough information available for staff to ensure all people who were prescribed medicines as and when required (PRN), received them consistently and when needed. PRN protocols were in place for some medicines, but not for others.
- The stock balance checks we completed showed records regarding administration were not always accurate, as not all the stock balances were correct.
- Although records showed that staff had completed training in the safe management of medicines, there were no competency assessments available to evidence staff could safely administer medicines. Following the inspection, the manager provided new medication competency assessments for some staff.

Failure to ensure medicines are managed safely, is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records were maintained to show when topical medicines such as creams had been applied, and people's allergies were recorded on their medication records.

Preventing and controlling infection
● Appropriate infection prevention and control measures were not all in place to prevent the spread of infection.
● Not all areas of the home had been adequately cleaned. Although cleaning schedules were in place, they evidenced gaps in their completion, did not cover all areas of the home and equipment, and there was little evidence of deep cleaning.
● There was no cleaning staff available over the weekend and no records that any cleaning took place during these times.
● Systems in place to ensure everybody completed COVID-19 testing in line with current government guidance were not effective. Although records showed staff completed weekly PCR tests, LFT tests had not been recorded for several months for some staff.

Failure to effectively control and prevent infections is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had access to adequate supplies of PPE and had undertaken training in infection control and the proper use of PPE.
● Systems were in place to ensure safe visiting in line with government guidance.
● Since the inspection, the manager told us they had recruited an IPC compliance officer to help make the necessary improvements.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.
● Records showed that staff had received vaccinations against COVID-19 and a new system had been implemented to evidence professional visitors also adhered to the requirements.

Staffing and recruitment
● Staff recruitment records showed that all staff had a disclosure barring check prior to commencing in post, to ensure they were suitable to work in the care sector. However, not all other safe recruitment practices were always adhered to.
● One file did not contain a reference from the previous employer, as required. The references available were not verified, and some not named, signed or dated. Another file did not reflect the staff members full employment history.

We recommend that the provider reviews and updates its processes to ensure all safe recruitment practices are robustly followed.

● Staff and people's relatives told us there were usually enough staff on duty to meet people's needs safely. Comments included, "Staff have time to sit and chat with residents", "You never hear the call bells ringing for long" and "There are enough staff. It is hard work though sometimes." We also observed staff taking time to sit and chat with people during the inspection.
● Agency staff were utilised to maintain staffing levels and staff told us the same agency staff were usually used so people living in the home were supported by people that knew them and how they wanted to be

supported.

Systems and processes to safeguard people from the risk of abuse
● A safeguarding policy was in place to guide staff in their practice.
● Staff we spoke with were aware how to raise any concerns they had, although records showed that not all staff had undertaken safeguarding training recently.
● Records showed that referrals had been made appropriately to the local authority when required.
● People's relatives told us they felt their families were safe living in Hillgrove. Comments included, "I am happy with the home, my [relative] is safe and she is well looked after", "The day [family member] went in there I felt reassured; she was safe and that is more important than anything else" and "[Relative] is safe and well-cared for at Hillgrove, I don't worry any more. It has changed my life as well as hers."
● People appeared to be happy and settled during the inspection, moving freely around the home and interacting with staff and each other.

Learning lessons when things go wrong
● Records showed that accidents and incidents had been monitored and recorded. Audits were completed to look for trends and help reduce the risk of further incidents.
● Records showed appropriate action was taken in response to any accidents and incidents and advice was sought from other health professionals when needed.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection we made a recommendation that the provider ensured the rating for the service was displayed on their website as required. During this inspection, we found that this had been acted upon and the rating was displayed within the home and on the website as required.

- The registered manager, who is also the provider, had stepped back from the day to day running of the home. A new manager had been appointed and planned to register with CQC to become the registered manager.
- The Commission had been informed of all notifiable incident's providers are required to inform us about.
- A range of policies and procedures were in place to help guide staff in their roles.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The systems in place to monitor the quality and safety of the service were not effective.
- Some audits had been completed; however, they were not all completed regularly, and did not identify the issues we highlighted during the inspection, such as those regarding medicine management, risk management, staff recruitment and infection prevention and control.
- Health and safety audits had not been completed since August 2021, and we found required checks on the building and equipment, had not been completed regularly to ensure safety.
- There was a lack of evidence of oversight for the service. The manager did not oversee the systems in place within the home to ensure safe and high-quality care was provided. The manager told us they met with the provider each week to provide an update on the service, and the provider confirmed this. However, there was no recorded evidence of this.
- Systems were not in place to gather regular feedback from people or their relatives, regarding the service provided, to enable changes and improvements to be made as necessary.
- Relatives told us they had not been involved in the creation or reviews of their family members plan of care.
- There was no evidence of staff meetings, although the manager told us that as they were new in post, they had been speaking with staff on an individual basis to help get to know them.

Failure to ensure effective systems were in place to monitor the quality and safety of the service is a breach

of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A new manager was in post. Not all relatives were aware of this but had no concerns as to how the home was run. One relative told us, "Yes I am happy with the management of the home. They will ring and let you know about even minor things."

● Feedback from relatives regarding the quality of care provided to people was positive. Comments included, "[Staff] do their best to care for each resident as an individual and they treat them with respect" and "My [relative] has a good relationship with staff, they are always laughing and joking."

● Measures had been taken during the COVID -19 pandemic to facilitate people having contact with their relatives. A relative told us, "Visits during Covid were always encouraged. I had a special phone number for [family member] and the carer would bring her to the phone and I could wave and see she was all right via Skype."

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

● Accidents and incidents were reviewed and acted upon to ensure the service acted in a transparent way.

● Relatives told us they were always kept informed of any incidents regarding their family members. They told us, "They always ring me if they have any concerns about her health" and "If there is conflict or difficult situations with my [relative], they always keep me informed and I am pleased about that."

Working in partnership with others

● Records showed that people were referred to other health professionals for their expert advice when needed. Staff told us they had good support from the local GP, who undertook weekly visits to the home.

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 Risks to people had not always been assessed or mitigated to maximise people's safety. Medicines were not always managed safely. Appropriate infection prevention and control measures were not all in place to prevent the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and safety of the service were not always effective.