Hillbro Nursing Home Limited

Hillbro Nursing Home

Inspection report

Holden Lane
Shipley
West Yorkshire
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29 September 2020
30 September 2020
01 October 2020
06 October 2020
13 October 2020

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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
Hillbro is a nursing home providing personal and nursing care to older people and people living with dementia. Hillbro accommodates 43 people in one adapted building. At the time of the inspection there were 42 people using the service.

People's experience of using this service and what we found
People were not always safe. Safeguarding procedures were not consistently followed. Robust moving and handling plans were not in place and people were at risk of injury. Audits and checks were in place to monitor the quality of the service. Improvements were required to ensure they highlighted all shortfalls promptly. The registered manager was approachable and visible. The management team were open and honest throughout the inspection and responded promptly to the issues we raised.

Recruitment was managed safely. People were cared for by an experienced and consistent staff team. People who used the service and relatives provided consistent positive feedback about their experiences of the care. One relative said, "The staff are first class; I think they do a good job." They said the staff team were kind and caring.

The home and grounds were accessible and well maintained.

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 the service was good (published 14 February 2019).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safeguarding concerns. A decision was made for us to inspect and examine those risks.

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.

We inspected and found there was a concern with safe care and treatment and reporting safeguarding incidents, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 improvements. Please see the safe and well-led sections of this report.

The provider took immediate action to mitigate the risks.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hillbro 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 assessing and managing risks to people, governance and safeguarding people from abuse.

We have identified a breach in relation to failure to notify CQC about significant events.

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

Follow up
We will continue to monitor information we receive about the service until we 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 findings below.

Hillbro Nursing 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 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
Two inspectors carried out this inspection 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 service.

Service and service type
Hillbro 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 inspection was unannounced. Inspection Activity started on 29 September 2020 and ended on 13 October 2020. We visited the service on 29 September 2020.

What we did before the inspection
We reviewed information we had received about the service which included concerns shared with us and feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what

they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We observed care and support in communal areas of the home. We spoke with three people who used the service and 11 relatives about their experience of the care provided. We spoke with 10 members of staff including the nominated individual, registered manager, nurse, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We talked with people who used the service, relatives and staff on the telephone after the site visit.

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

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 good. At this inspection this key question has now deteriorated 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider did not consistently follow safeguarding procedures. Some safeguarding incidents had not been reported to the local safeguarding authority or CQC.
- Accidents and incidents were recognised by staff and reported. We saw examples of lessons being learned and the follow up action taken. However, where incidents had taken place between people at the home this had not been referred to safeguarding. This meant that there was no monitoring or oversight by external bodies.

The provider did not ensure systems and processes safeguard people from abuse. This places 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.

- Staff received safeguarding training. They understood the different forms of abuse and reported their observations of incidents.
- Where safeguarding incidents had taken place, staff took steps to support and reassure people.
- People and relatives confirmed they felt safe. One relative said, "I am sure [person] is well looked after and they have kept them all safe during the pandemic, which I am so grateful for. I have no qualms."

Assessing risk, safety monitoring and management

- People's moving and handling plans were not detailed. There was no information to indicate what size or type of sling was required. Staff did not know what size sling to use. They confirmed they worked in pairs to support people, but we received conflicting information from staff. This meant people were not supported consistently and they were at risk of discomfort or harm from risk of falling.
- People did not have their own slings and the process for laundering and minimising cross infection was not effective.
- We observed staff reassuring and talking with people when they were moving and handling them. However, we were not assured this was done safely as staff did not have the information to ensure the correct size sling was used.

We found no evidence that people had been harmed however, 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 provider took immediate action. Individual slings were purchased for people. People's care plans were updated to include information to ensure they were supported safely.

● Other risks to people's health and safety were assessed. A range of risk assessments were in place including information about bed rails, falls, eating and drinking and pressure care.
● Where people experienced periods of distress or anxiety staff knew how to respond. Care plans contained person centred information about how to support people.
● Safety and environmental checks were undertaken, and action taken when issues were identified.

Staffing and recruitment
● People and relatives said there were enough staff. One person said, "I feel safe, I have to be. You just have to ring a bell". Another person said, "I love it, they are all very kind, they do things for me. I wouldn't live anywhere else."
● Staff said there were enough staff on duty although some care workers said morning shifts were busy and it was sometimes hard to find time to chat and spend time with people.
● The registered manager confirmed staffing was reviewed dependent upon people's needs. They did not use a recognised dependency tool to calculate this. We discussed this and they confirmed they would review this, so they were assured staffing levels were systematically monitored and reviewed.
● Robust recruitment procedures were in place to ensure only staff suitable to work were employed.

Using medicines safely
● Medicines were managed safely. The provider operated an electronic medication record which recorded people's medicines clearly. Designated staff received training and their competence to administer medicines was regularly assessed.
● Robust monthly audits were completed, and the outcomes discussed with the nursing team.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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 now deteriorated to requires improvement. 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.

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

● Registered providers are legally obliged to inform the Care Quality Commission (CQC) of certain incidents which have occurred within the home. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service.

Notifications about some significant events had not been submitted to CQC. The provider did not always report allegations of abuse. This meant they did not fulfil their legal responsibility.

Failure to submit required notifications meant CQC were not made aware of some notifiable events so were unable to carry out their monitoring role. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2009.

Following our inspection and upon raising concerns with the registered manager statutory notifications have been made to CQC.

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

● A range of audits and checks took place to identify concerns and improve service provision. They included buildings, staffing levels, training and medicines. Generally, they were effective and where issues had been identified follow up action had been taken. However, shortfalls were identified in monitoring safe moving and handling for people and reporting allegations of abuse.

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

Following our inspection, the provider confirmed additional checks had been introduced.

● The service used an electronic care record system. This allowed the registered manager to have good oversight of people's care needs. Care records had been updated monthly or when changes occurred.

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

● The management team were visible and approachable. The registered manager maintained daily oversight of the home. There was an open culture in the home and staff praised the way the home was run. One care worker said, "It's a great home. It's run well."

● Staff worked well together and demonstrated team work. Staff meetings were held regularly. Records showed there was an opportunity for quality issues to be discussed and for staff to share ideas.

● People and relatives felt involved in the day to day running of the home. They were complimentary of the registered manager and staff team. They said they had been kept informed and updated throughout the period of COVID-19 pandemic. One relative said, "[Registered manager] is very nice, very welcoming, very approachable, very obliging. Most of the time staff seem happy, they seem to pull together. It seems a well-run home."

Continuous learning and improving care; Working in partnership with others

● Accidents and incidents were reviewed and used to inform plans.

● The provider engaged with the local registered manager and care association networks. The home had established links with local community groups.

● Records showed staff engaged with a range of health and social care professionals.

● Throughout the inspection the provider and the registered manager were responsive to feedback. They demonstrated commitment to improving the service so they could deliver optimum care to people.

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 provider failed to assess or manage risks associated with people's care. The provider did not ensure people were supported with moving and handling safely. Reg 12 (2) (a) (b) (e) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure systems, processes and practises safeguard people from abuse. Reg 13 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust systems and processes were not always in place to assess, monitor and improve the safety of the service. Reg 17 (2) (a) (b) (c)