Hilbre Care Limited

Bidston Lodge

Inspection report

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Birkenhead
Merseyside
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Date of inspection visit:
01 August 2019
08 August 2019
20 August 2019

Date of publication:
30 September 2019

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Bidston Lodge is a residential care home providing accommodation and personal care to 10 people aged 65 and over at the time of the inspection. The service can support up to 16 people in one adapted building.

People's experience of using this service and what we found
The service was not well-led. The systems at the home were not used by the home manager and registered manager to assess the quality and safety of the service effectively. They were at times not able to use their systems to provide us with basic information about the service provided for people. When concerns had been raised they were in some areas slow to react or reacted in a way that was not effective; this meant that at times things went wrong again in a short timeframe.

The provider had not put a system in place to ensure that recruitment process followed the regulations and was safe.

The provider and registered manager had not ensured that the culture of the home was always respectful and empowered people to have maximum control and choice over their lives. Staff did not always support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Consulting with people in a meaningful way was not embedded into the culture of the service.

We recommended that the provider consulted with people about their preferences with their care and support; and arranged people's care to meet these preferences as much as possible.

People's medication was administered safely at the home. We have made a recommendation that the provider ensures that there was a system in place for recording all medication stocks on hand.

People told us that they felt safe living at Bidston Lodge. People and their relatives told us that they thought they were treated with respect. One person told us, "The staff are fantastic."

The home was well decorated in a homely style. One person told us, "I like it here, it's lovely." The provider had made improvements to the design of the home to meet people's needs. For example, they had recently arranged for new accessible bathroom facilities to be fitted on the ground floor.

Care staff told us that they felt supported in their roles. They spoke positively about the new provider and told us that the atmosphere at the home had improved since they took over.

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

Rating at last inspection

This service was registered with us on 28/04/2019 and this is the first inspection.
The last rating for this service was inadequate (published 9 April 2019). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating and enforcement action taken to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the safe management of the home. A decision was made for us to inspect and examine those risks.

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

Enforcement
We have identified breaches in relation to person-centred care, safe care and treatment, fit and proper persons employed and good governance at this inspection.

During the inspection the provider took action to mitigate some of the risks that had been identified. You can see the action we have told the provider to take at the end of this report. This included issuing the provider with a warning notice. If the provider fails to achieve compliance within the timescale on the warning notice, we may take further action.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Bidston Lodge

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
This inspection was completed by a team of three inspectors, each visit to the home was made by two inspectors.

Service and service type
Bidston Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. They are referred to in this report as the registered manger.

The day to day running of the home had been delegated to a home manager. They are referred to in this report as the home manager; to distinguish them from the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority. We used the information in the initial report from the local authority's food hygiene visit.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and two people's relatives about their experience of the care provided. We spoke with five members of staff including the registered manager and home manager. We also spoke with the provider.

We reviewed a range of records. This included four people's care plans, 10 people's daily care records and multiple medication records. We looked at four staff files and information for four bank members of staff. We looked at a variety of records relating to the management of the service including audits and policies.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This related to information concerning bank staff, staff meetings and health and safety checks.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Sufficient attention was not consistently given to the safety of the home. For example, five weeks before our inspection, the home had a visit from the local authority to check the standards of food hygiene. The visit highlighted a number of concerns; some of which needed addressing quickly. The registered manager and home manager were involved in the food standards inspection and had been given a summary of the actions required. However, none of the actions had been started in these five weeks; despite many of them being straightforward.

● Some areas of food safety had further deteriorated in these five weeks. For example, records of food cooking and storage temperatures had not been made and there were no recent records to show what cleaning had taken place of the food preparation areas. Also, we found some food stored in unsuitable conditions and rotten food outside the kitchen which risked attracting vermin.

● Assessing the safety of the home had not been effective. The home manager completed a daily walk around. This is described as a check on residents, staff, premises and audits. These checks had not been effective in assessing risk and monitoring people's safety. For example, they had not highlighted that the frame of the fire door for the boiler room had significantly warped. This meant that the fire door could not be closed and was always open and they had not highlighted the poor practises and poor record keeping in relation to food safety.

● We saw on our early morning visit that one person's bedroom door; which was a fire door to offer protection in the event of a fire, was held open with a chair whilst the person was asleep in bed. This is an unsafe practise. Also, records provided by the home manager showed that only one staff member had received fire safety training.

The systems put in place by the provider had not been effective in assessing and managing risks at the home to ensure people were safe.

This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had arranged for other safety checks of the building to take place. The home had recently had a new fire alarm fitted.

Learning lessons when things go wrong

● When concerns were raised about the safety or quality of the service being provided the home manager and registered manager were in some areas slow to react or reacted in a way that was not effective; this meant that at times things went wrong again in a short timeframe.

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

Staffing and recruitment

● One of the checks providers are required to make before employing a person to provide a regulated activity is their previous conduct in health and social care roles; and why that employment ended. Usually this is done using references. This helps providers ensure that they make safe recruitment decisions.

● The pre-employment checks completed at the home did not always do this. The provider had not put a system in place to ensure that recruitment process in this and other areas followed the regulations and were safe.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The number of staff available at the home was inconsistent. On some days there was additional staff available to help the two allocated care staff with cooking, cleaning and laundry and on other days there was not and these tasks were completed by the two care staff in addition to caring for 10 people.

● The provider agreed that more help was needed and they were in the process of recruiting for kitchen and cleaning staff and planned to increase care staff available during the busy morning period. Care staff we spoke with told us that they thought there was enough staff at the home.

Using medicines safely

● Each person had a medication profile which contained information on their prescribed medication and any allergies they may have. We saw that people's medication was administered safely at the home.

● We had some concerns about the recording of medication stocks. When new stocks arrived, the amount of stock remaining and carried over was not recorded. This made it difficult to work out if the stock on hand was correct at any time.

We recommend the provider ensure that there was a system in place for recording all medication stocks on hand.

Systems and processes to safeguard people from the risk of abuse

● People told us that they felt safe living at Bidston Lodge.

● There was information readily available for staff on how to raise a safeguarding alert along with the relevant contact details. Staff told us that they had received training in safeguarding vulnerable adults and felt confident in raising a concern if they needed to.

● The home manager kept a record of any safeguarding concerns, actions taken to keep people safe and any outcomes of safeguarding investigations.

Preventing and controlling infection

● The home was clean. There was appropriate washing and cleaning facilities and gloves and aprons were available for staff.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Some of the training that the provider used was computer-based e-learning. We looked at the records and saw that there were significant gaps for care staff in the training that the provider viewed as mandatory. The registered manager told us that this was being worked on and improvements would be seen in the next two weeks.
- New staff received an induction into their role and had a period of shadowing more experienced staff members. Staff told us that this supported them and helped them to be prepared for the role.
- Staff were supported with supervision meetings, an appraisal of their performance and team meetings with the home manager. Staff members told us that they found these meetings useful.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider had a system for assessing a person's needs both before they came to the home and for getting to know they when they came to the home.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us that they liked the food provided for them and they had choice for their main meals.
- People's care plans contained guidance on how to support people to have a healthy and balanced diet. People's appetite and weight was regularly recorded, this enabled staff to know that people had a balanced diet and to take appropriate action if they noticed any concerns.

Adapting service, design, decoration to meet people's needs

- The home was well decorated in a homely style. One person told us, "I like it here, it's lovely."
- The provider had made improvements to the design of the home to meet people's needs. For example, they had recently arranged for new accessible bathroom facilities to be fitted on the ground floor.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care

- People received support with their healthcare needs; they were supported to organise and attend healthcare appointments and GP visits.
- Staff made appropriate referrals for people and supported them to access additional healthcare services when needed.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The home manager had applied for a DoLS for a number of people who did not have the capacity to consent to their care and accommodation at the home.
- We saw that these DoLS were in date, had been regularly reviewed and an conditions on the authorisations were being met.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people were not always treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always spoken about in a respectful and dignified manner. For example, people using the toilet were spoken about out loud across the home, as a task to be completed.
- People and their relatives told us that they thought they were treated with respect. One person told us, "The staff are fantastic." Another person's relative had written to the home and said, "The staff are excellent, the food is excellent… the difference in [name] from coming from hospital is amazing."

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not consistently protected. The provider had installed a CCTV system that was designed to monitor entrances and exits from the home. This operated 24 hours a day and was recorded. One sitting area within the home was captured by one of the cameras. On the second day of our visit we asked the registered manager what actions had been taken to notify and consult with people living at the home as they may be recorded in one of the sitting areas. No actions had been taken.
- By the third day of our inspection the provider still had no policy for the use of CCTV within the building and they had not assessed or mitigated the risks to people's privacy.
- In other areas people's privacy and independence had been promoted. For example, people's care plans and records were in a locked office or on a password protected computer; and people who had capacity were supported to manage their own mail and correspondence.

Supporting people to express their views and be involved in making decisions about their care

- The provider had held two meetings with people living at the home and their relatives to ensure people had relevant information and to obtain their views. However, consulting with people in a meaningful way about their care was not embedded into the culture of the service. The provider and staff were at times making decisions without considering people's views.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- On the second day of inspection we arrived at the home at 7am, to check if people's support in the morning was meeting their needs and reflecting their preferences. We saw that seven of the ten people at the home had already been supported to get ready for the day and to have breakfast. Staff had provided six people with tea and toast in the lounge and one person was using the dining room.
- Night staff told us that everybody who needed support to get up; had been supported to get up, have their personal care needs met and have breakfast by 7am. Staff told us that they started getting people out of bed at 5:45am. Records indicated that this was the usual morning routine at the home.
- One person independently used the dining room. The other six people were provided with tea and toast in the lounge. There was one type of bread available; the provider told us that this bread was chosen as it was a mix of wholemeal and white. Night staff told us that people could have something different if they asked for it. However, there was no designated staff available to prepare different breakfast options at that time.
- We asked one person if they liked getting up early. They told us, "No I don't; but they get me up. I might have a snooze in the chair." Another person said, "Staff come to get you up; and I have to get up anyway, so I might as well get up now."
- There was no evidence that people's preferences with regard to their morning routine had been explored. People's care plans did not contain details of their preferences and what time they liked to get up.
- The nominated individual told us that it was important for people that they had a routine and that in every care home there will be an expectation that night staff get three or four people up. However, people's care and support in the morning did not promote choice, enable people to maximise their control and was not responsive to their preferences.

This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommended that the provider consulted with people about their preferences with their care and support; and arranged people's care to meet these preferences as much as possible.

The home manager and the nominated individual told us that they would review people's morning care and support.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Each person's care plan contained details on their communication needs along with guidance for staff to help ensure that people understood the information provided for them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● On occasion people had been supported to visit local places of interest and reduce social isolation. For example, people were supported to attend a barbecue at one of the providers other homes and people had had fish and chips at the seaside.

● Some people had a social activity care plan that provided information for staff on how people liked to spend their time.

Improving care quality in response to complaints or concerns

● The home had a policy in place for responding to complaints and concerns raised at the home. The home kept a record of complaints raised and actions taken by the provider.

● The provider made the details of outside bodies that people could raise a complaint with available to them.

End of life care and support

● Nobody at the home was receiving end of life care during our inspection. Experienced staff had received training in how to care for and support people at the end of their lives.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- The systems at the home did not enable the home manager and registered manager to assess the quality and safety of the service. There were significant gaps in people's care records and other systems that the home used to operate. The home manager and registered manager were not able to use their systems to provide us with basic information about the service provided for people. For example, what staff members provided care on recent dates at the home; or the start date for a new staff member.
- The home managers daily walk around had not been effective in assessing the safety and quality of the service provided. For example, concerns with safe food storage, safe food records and an ineffective fire door. These checks had not highlighted any concerns or resulted in any action being taken.

Continuous learning and improving care

- When the provider became aware of concerns about the safety or quality of the service they had not always ensured that improvements had been made in a reasonable timeframe.
- The home manager and registered manager were in some areas slow to react or reacted in a way that was not effective; this meant that at times things went wrong again in a short timeframe.

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 had not consistently provided information to the CQC that they were obligated to do so.

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

- The provider and registered manager had not ensured that the culture of the home was always respectful and empowered people to have maximum control and choice over their lives. For example, there was no evidence that people's morning preferences had been explored with them; that they had been empowered to make choices in how they started their day or that the quality of people's support in the morning had been assessed.

The provider had been ineffective in assessing, monitoring and improving the safety and quality of the service including the quality of the experience of those using the service.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others

- The provider had arranged for two meetings over recent months with people living at the home and their family members.
- Staff spoke positively about the provider, they told us that the atmosphere had improved since the new provider took over and they feel consulted by them.

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 9 HSCA RA Regulations 2014 Person-centred care People's care and support in the morning did not promote choice, enable people to maximise their control and was not responsive to their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems put in place by the provider had not been effective in assessing and managing risks at the home and ensuring people were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not put a system in place to ensure that recruitment process followed the regulations and was safe.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not been effective in assessing, monitoring and improving the safety and quality of the service; including the quality of the experience of those using the service.

The enforcement action we took:

Issued the provider with a warning notice.