Scope

The Hollies

Inspection report

1-3 The Hollies
Halton Brook Avenue
Runcorn
Cheshire
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Date of inspection visit:
19 February 2016

Date of publication:
03 May 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook a focused inspection of The Hollies on the 19 February 2016.

When we carried out our last inspection of the home on 30 October and 3 and 9 November 2015, the registered persons were found not to be meeting all the requirements for a service of this type. We identified breaches of the relevant regulations in respect of the need for consent, safe care and treatment, nutrition, good governance, and staffing and an overall rating of requires improvement was awarded.

We carried out this inspection in response to concerns raised by a representative of Halton Borough Council about the standard of care provided at the home and to follow up on warning notices we served following our previous inspection of the home in 30 October and 3 and 9 November 2015.

1– 3 The Hollies is a purpose built care home comprising of three separate bungalows providing personal care and accommodation for up to nine people who have a physical disability. Each bungalow has three bedrooms, separate lounge, kitchen dining room and bathroom and toilet. The premises are equipped and adapted to meet the needs of the people who live at the home. There is level access to each property and tracked ceiling hoists have been installed where required. Each bungalow has its own garden area and off road parking is available for several vehicles. Staff and the people who use the service have the use of a small office which is located adjacent to bungalow 3.

The home is located in a residential area of Runcorn and is within easy access of the local amenities. On the first day of our inspection there were nine people living in the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following our previous inspection in October and November 2015 the registered persons sent action plans which set out what action they had taken and were taking to improve the service to ensure that people received safe and effective care.

During this inspection we found that there were times when there were insufficient numbers of staff on duty, to provide a safe service to the people who lived in the home, managers were not learning from experience and vulnerable people were at risk of receiving unsafe and ineffective care.

We identified further breaches of the relevant regulations in respect of safe care and treatment, good governance, and staffing. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

The health and well-being of the people who lived at the home was at risk because the registered persons were failing provide care in accordance with each person's assessed needs.

Managers and staff were not doing all that was reasonably practicable to identify, control and mitigate risks and ensure that people were protected from unsafe and ineffective care.

There was an insufficient numbers of suitably, experienced qualified and competent staff to ensure the well-being of the people who lived at the home.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager had not taken effective action to address care practice failings identified at our last inspection so vulnerable people had remained at risk of receiving unsafe care.

The registered manager had failed to delegate effectively and consistently failed to monitor, over time, whether the arrangements made for the care of vulnerable people were sufficient to ensure their welfare.

The Hollies

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
We undertook a focused inspection of The Hollies on the 19 February 2016. We carried out this inspection in response to concerns raised by a representative of Halton Borough Council about the standard of care provided at the home and to follow up warning notices we served following our previous inspection of the home in 30 October and November 2015.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This was because the findings of our previous inspection and concerns subsequently raised by Halton Borough Council highlighted a risk that the registered persons may not meeting legal requirements in relation these questions.

The inspection was undertaken by one adult social care inspector.

We reviewed the information the Care Quality Commission already held about the home. We contacted the local authority safeguarding, contracts monitoring, and learning disability teams before and after the inspection and they shared their current knowledge about the home. During the inspection we spoke with all nine of the people who lived at the home. We talked with six members of staff including three members of the care staff team, the registered manager, team leader and area manager. We looked at four care and support plans as well as other records and audit documents. We looked around the building including, with the permission of people who used the service, some bedrooms.

Inadequate

Is the service safe?

Our findings

When we carried out our last inspection of the Hollies in October and November 2015 we found that arrangements made to ensure that people received safe care and treatment were inadequate. There had been times when the registered persons had not done all that was reasonably practicable to mitigate risks to the health and welfare of the people who lived at the home or deployed sufficient numbers of suitably qualified, skilled and experienced staff to meet their assessed needs and ensure their wellbeing. We took enforcement action and served warning notices. We told the registered persons that they must comply with the requirements of the regulations and ensure that people receive safe care and treatment by the 6 February 2016.

On the 5 February we received information from representatives of Halton Community Learning Disability Team who told us that speech and language therapists (SALT) had visited the home on 23/11/15, 29/12/15 and 12/01/16. On each occasion the speech and language therapist had cause to raise concerns with the team leader because they had found that staff were not following eating and drinking guidelines. This meant that people were at risk of choking and / or aspiration.

A representative of the local authority's Integrated Adult Safeguarding Unit told us that they had visited the home on the 4 February 2016. They told us that they found that SALT guidance given for a service user at risk of choking was not recorded in the person's risk assessments which recorded "no needs", in the eating and drinking section of the document. These concerns were raised and discussed with the registered manager of the home and the area manager at a meeting convened by the local authority on the 8 February 2016. Assurances were given by the area manager and registered manager that action would be taken to address these concerns and ensure that the people who lived at the home were safe.

On the 19 February 2016 we received information from Halton Borough Council further to a contracts monitoring visit they had started to carry out at the home on the previous day. The information they shared with us indicated that they had found evidence that vulnerable people were still being placed at serious risk to their health and wellbeing. In response we instigated this focused inspection. We started our inspection at 3pm on the 19 February 2016.

The contracts officer from Halton Borough Council was present in the home at the time we started our inspection. They told us that they had found that managers and staff were not following eating and drinking guidelines and as a result a vulnerable person was put at risk of choking. Records showed that a vulnerable person who had been assessed at risk of choking by their speech and language therapist had been left alone and unsupervised in their bungalow on the 4 February 2016. Whilst unsupervised they had helped themselves to unprepared fruit from a fruit bowl. This was contrary to their eating and drinking guidelines and put them at high risk of choking. The contracts officer told us that on the 18 February 2016 they had observed this person again alone and unsupervised in their bungalow. They had again had unsupervised access to a bowl of unprepared fruit and again were placed at high risk of choking. The contracts officer told us that they raised this concern with the registered manager who had instructed the team leader to remove the fruit bowl and inform the staff of the hazards that this had presented to the vulnerable person. The

person's risk assessment had not been updated since the incident on the 4 February, there had been no analysis of what had gone wrong and no action taken to prevent a further recurrence until the contracts officer intervened.

Further concerns raised by the contracts monitoring officer led us to look at the records of a person who was prescribed medication by their doctor to be administered by the district nurse twice a week. This person required careful monitoring by staff to ensure the medication was effective. We could see that staff were monitoring this person but had failed to take appropriate action when there were indications that the medication was not effective. We could see that approximately four weeks before our inspection this person's doctor had reduced their medication to one administration per week subject to review. We looked through this person's daily notes and found no evidence of staff reviewing this person's wellbeing since their doctor had changed their prescription and there was no evidence they had sought medical attention regarding potential ineffectiveness of the medication. We looked through their care records and could find no evidence that risks had been assessed and the care plan relating to this health need had not been reviewed or revised in the light of their changing needs.

At our last inspection we identified that a person was placed at risk of harm because managers and staff had not responded effectively when an incident highlighted that they were unable to summon assistance from staff when they had a severe epileptic seizure. The problem was exacerbated because the two night staff on duty congregated in the middle bungalow and this person lived in one of the other bungalows. They had not given consideration as to how the risk of harm could be minimised in the future, such as the use of assistive technology to activate the alarm automatically in the event of another seizure during the night. We wrote to the manager during our inspection highlighting these concerns and in response we were told that the use of assistive technology was being explored and one of the two night staff would be located in the person's bungalow. However, on the 19 February the manager told us that suitable assistive technology had been identified but was not in place and night staff were still congregating in the middle bungalow at night time. This meant that the hazards we had previously highlighted were still not being mitigated.

On the 29 February 2016 we received information from the local safeguarding authority that they had received a safeguarding alert from a speech and language therapist who had visited the home that day. They had witnessed that a vulnerable person who was assessed as at risk of choking was left unsupervised eating a meal in their bedroom. This is contrary to their eating and drinking guidelines which identified that the person must be supervised at all times whilst eating. The speech and language therapist witnessed the person choking and had to intervene. Staff were in the kitchen at the time this incident was taking place. They appeared not to notice that the person was choking showing little awareness of the severity of the situation. On the 1 March 2016 representatives from the safeguarding authority visited to investigate the allegations raised by SALT. They found that the allegations were substantiated.

All the issues above constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered persons were not doing all that is reasonably practicable to mitigate the risks to the health and welfare of the people who lived at the home.

When we carried out our last inspection of The Hollies in October and November 2015 we found the registered persons had not always deployed sufficient numbers of suitably qualified, skilled and experienced staff to meet the assessed needs of the people who lived at the home.

The contracts monitoring officer told us that they had found that on the 18 February 2016 there was an insufficient number of suitably qualified, skilled and experienced staff on duty to meet the assessed needs of

the people who lived at the home. The contracts officer witnessed staff struggling to meet the needs of people who used the service. At one point they witnessed one staff member dispensing medication when a service user had an accident and needed assistance to change their clothes. At the same time another service user requested to go on the toilet and simultaneously the staff member working in the bungalow next door, who had been supplied by an employment agency, came over to request support. The agency worker had requested support because they had not been shown how to use the hoists. The staff member stopped dispensing medication, assisted one service user to the toilet and left them there whilst they went next door to show the agency worker how to use the hoists. The person who was on the toilet persistently sounded the alarm call but their calls for support were not responded to because staff were supporting others in the bungalow next door.

We spoke with five of the people who lived at the home about staffing levels and they all told us that there was insufficient staff on duty. They told us that their needs were not met because they did not have the support they needed to socialise and engaged in activities in the local community. We looked the activity records for January 2016 regarding the activities undertaken by four of the people who lived at the home. The records showed that three of the four people had been out but only once. The fourth person had not been out at all. In the section of the report which recorded "What had not worked this month" staff had recorded the reason for lack of activities was due to staffing levels in three of the four cases.

We asked the team leader how many staff were required to ensure the needs of the people who lived at the home were met. The team leader told us that a minimum of four support workers were required throughout the day time period to meet the needs of the people who lived at the home. However, as we could see from the staff rotas there were several times since the beginning of the year when only three staff were on duty, due to staff sickness. On a number of occasions we could see that staff employed on a temporary basis, known as agency staff, had been deployed to make up the numbers. However, on three occasions records showed only two of the homes staff had been deployed supported by just one agency support worker.

The issues outlined above comprise a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered persons did not always deploy sufficient numbers of suitably qualified, skilled and experienced staff to meet the assessed needs of the people who lived at the home.

We asked the registered manager what arrangements had been made to ensure that agency staff were sufficiently skilled, competent and knowledgeable about the needs of the people who lived at the home. The registered manager was unable to tell us whether agency staff had been given any induction training and referred us to the team leader. It transpired that no arrangements had been made to provide agency staff with any form of induction training or familiarisation with the needs of the people who lived at the home. We spoke with an agency worker who was working in one of the bungalows alone. We asked them basic questions about the needs of the people who lived at the home. They were unable to tell us which of the people who lived at the home had been assessed as at risk of choking and they did not know that one person was subject to a deprivation of liberty authorisation. When we enquired further it was apparent that they had did not know what a deprivation of liberty authorisation was. This showed that staff had not received such appropriate training and support as is necessary to ensure the wellbeing of the people who lived at the home.

On the 1 March 2016 representatives from the safeguarding authority visited to investigate the allegations raised by SALT. In relation to the allegation that staff did not respond effectively when a person was choking they asked the registered manager to confirm what training staff had received regarding choking. The manager told them that staff had not received any specific training as to what action they should take if a

person was found to be choking. On the 3 March 2016 we contacted the manger by telephone and asked whether staff had received training on what action to take in the event of a person choking. The manager told us that they did not know whether staff had received any specific training in respect of choking and gave assurances that he would contact SALT to arrange the required training. This showed that staff had not received such appropriate training and support as is necessary to ensure the wellbeing of the people who lived at the home.

The issues outlined above comprise a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered persons did not always ensure that staff received such appropriate support and training as is necessary to meet the assessed needs of the people who lived at the home.

Inadequate

Is the service well-led?

Our findings

When we carried out our last inspection of the Hollies in October and November 2015 we found that arrangements made to ensure the service was well led required improvement. Systems and processes established to ensure compliance with the regulations had not been used effectively to identify and solve problems and ensure the welfare of the people who lived at the home. Managers and staff were not routinely analysing accidents and incidents so opportunities to learn from past events and near misses were being lost.

Following our inspection in October and November 2015 the manager sent the Commission a series of action plans which showed that action was being taken to address the practice failings we had identified. They gave assurances to the Commission that these actions would ensure the well-being of the people who used the lived at the home. However, evidence provided by a number of health and social care professionals showed that these actions had not proved effective and as a result vulnerable people had remained at risk of receiving unsafe treatment and care.

We were given assurances that people who were assessed as being at risk of choking would receive the support they needed to eat their meals safely but we found evidence that eating and drinking guidelines were not adhered to. This was despite numerous and repeated concerns raised by health and social care professionals. The registered manager and area manager attended a meeting on the 8 February 2016 convened by the local safeguarding authority to address these concerns and the apparent inability of the registered person's to adhere to clinical guidelines and thereby ensure the welfare of the people who lived at the home. The registered manager and area manager gave assurances that effective action would be taken but again a contracts monitoring officer found that eating and drinking guidelines were still not being adhered to on the 18 February 2016. Despite the local safeguarding authority receiving further assurances on the 19 February 2016 that effective action would be taken to protect vulnerable people from inadequate care a speech and language therapist witnessed a person choking because staff had not followed eating and drinking guidelines on the 29 February 2016.

We found that life threatening hazards highlighted at our previous inspection associated with a person's epilepsy had still not been effectively risk assessed or mitigated. Action plans submitted to the Commission by the registered manager to acquire assistive technology and ensure close supervision by staff at night had not been put in place so the vulnerable person had remained at risk.

We again found that managers and staff were not routinely analysing accidents and incidents so opportunities to learn from past events and near misses were being lost. Records showed that a vulnerable person who had been assessed at risk of choking by their speech and language therapist had been left alone and unsupervised in their bungalow on the 4 February 2016. Whilst unsupervised they had helped themselves to unprepared fruit from a fruit bowl. This was contrary to their eating and drinking guidelines and put them at high risk of choking. The contracts officer told us that on the 18 February 2016 they had observed this person again alone and unsupervised in their bungalow. They had again had unsupervised access to a bowl of unprepared fruit and again were placed at high risk of choking. The person's risk

assessment had not been updated since the incident on the 4 February, there had been no analysis of what had gone wrong and no action taken to prevent a further recurrence until the contracts officer intervened.

The registered manager had not delegated tasks effectively. We found that staff were monitoring a person who had a health risk but they had not reacted effectively when it was evident that the person's medication had been ineffective on two separate occasions. When we asked the team leader why staff were monitoring this aspect of this person's health and wellbeing they told us that they did not know why, they said "it was something they had always done". There was no risk assessment regarding the hazards presented to this person's particular health risk and their care plan had not been revised in respect of their changing needs.

The registered manager was unable to tell us whether agency staff had been given any induction training and referred us to the team leader. In answer to our question the team leader told us that they had not been asked to give the agency workers an induction, they said "they had come at short notice". It transpired that no arrangements had been made to provide agency staff with any form of induction training or familiarisation with the needs of the people who lived at the home. We spoke with an agency worker who was working in one of the bungalows alone. We asked them basic questions about the needs of the people who lived at the home. They were unable to tell us which of the people who lived at the home had been assessed as at risk of choking and they did not know that one person was subject to a deprivation of liberty authorisation.

The registered person's responded to the issues we raised during our inspection and gave assurances that action would be taken bring about the necessary improvements. Following our inspection the registered persons wrote to the Commission and provided an action plan. We found that this action plan contained inaccurate and unsupported information which indicated that the concerns we had identified were lesser than they had appeared to us on the 19 February 2016. We sought clarification, corroboration and evidence that such records actually existed, the area manager told us that they had searched but no such records could be found.

The above issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.

The registered persons are required to notify the Commission of certain changes, events and incidents specified in the regulations. This is to enable the Commission to see if the situation was handled correctly and if the service provider is complying with the law. At the time of our last inspection we identified that the registered persons had not notified the Commission that a standard authorisation for a deprivation of liberty safeguarding (DoLS) authorisation had been granted in respect of the care of a person who lived at the home. We told the registered persons that failure to notify the Commission of such notifiable incidences is a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

On the 29 February 2016 a visiting speech and language therapist witnessed a vulnerable person choking because staff had not followed eating and drinking guidelines and had left the person unsupervised contrary to their assessed needs. The speech and language therapist reported this evidence of neglect to the local safeguarding authority without delay as in accordance with locally agreed adult safeguarding procedures. Representatives of the local safeguarding authority had visited the home on the 29 February 2016 to investigate the matter. They told us that they were concerned to find that the registered manager who was aware of the incident had not reported the matter themselves to the local safeguarding authority. On the 3 March 2016 we checked our records and found that the registered persons had not notified the Commission

of this incident which constituted a notifiable incident under the requirements of the regulation.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009. Notification of other incidents. The registered persons had not notified the commission without delay of any abuse or allegation of abuse.