Hilbre Care Limited

Hilbre Manor EMI Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hilbre Manor is a residential care home providing accommodation and personal care for up to 15 people in one adapted building over four floors with passenger lift access to each floor. At the time of our inspection 12 people were living at the home.

People's experience of using this service and what we found
The provider had not ensured that testing for COVID-19 was taking place at the home in line with government guidance. Some testing was not taking place and the records for other testing showed that its use was sporadic and incomplete. This meant that reasonable measures to help protect people from COVID-19 were not being used effectively.

Following our visit, we urgently raised our concerns and required an urgent action plan along with assurance from the provider that COVID-19 testing in line with government guidance and their own risk assessment, would take place. We are continuing to monitor the testing for COVID-19 at the service.

We have made a recommendation about infection prevention and control practices. Staff did not always wear face masks in line with government guidance.

The requirements for the safe recruitment of staff who carry out regulated activities in social care are laid out in law. The provider had failed to ensure that robust systems were in place that ensured these legal standards were consistently followed.

The provider had not ensured that robust procedures and systems were in place for the safe and effective administration of medication. The provider could not evidence that all staff who were administering medication had received appropriate training and had their competencies assessed to ensure that they were safe to do so. The providers own medication audits for three months had highlighted that not enough staff members had received the relevant medication training and had their competencies assessed in administering medication.

We have made a recommendation about staffing levels and the deployment of staff to fulfil necessary supporting roles.

At our previous inspection people's risk assessments and associated care plans did not always reflect the risks when caring for a person. At this inspection, risk assessments in place to monitor people's safety and wellbeing had been recently reviewed, updated and now reflected the risks present when caring for a person.

Since our last inspection staff had received safeguarding training and the systems in place to record safeguarding concerns had shown recent improvements. These improvements need to be sustained and

built upon to ensure that cultural change at the service is embedded.

At this inspection there had been some recent improvements in specific areas of the service. However, these were not embedded and there remained significant shortfalls in the quality of the service being provided. At six of the previous seven inspections dating back to 2015; Hilbre Manor has been in breach of Regulation 17, good governance. The provider over time, with different management structures in place has not been able to provide effective leadership, management and governance at the home for any sustained period of time.

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

Rating at last inspection (and update)
The last rating for this service was inadequate (published 16 January 2021) and there were multiple breaches of regulation. Following our last inspection, we took enforcement action to remove the registration of the registered manager.

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

At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains in special measures.

Why we inspected
This was a planned inspection based on the previous rating.

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.

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 monitor the service.

At this inspection we have identified breaches in relation to safe care and treatment, staff recruitment and governance. 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 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.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Hilbre Manor EMI Residential Care 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
This inspection was completed by two inspectors.

Service and service type
Hilbre Manor EMI Residential Care 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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 health and social care professionals who work with the service. We used all of this information to plan our inspection.

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.

During the inspection
We spoke with three people who used the service and one person's relative about their experience of the care provided. We spoke with five members of staff including the provider, care manager, and care staff.

We reviewed a range of records. This included eight people's care records and a sample of medication records. We looked at two staff members records in relation to safe recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection
We sought urgent assurances and an action plan from the provider to immediately address some of the concerns raised during this inspection. We reviewed some additional information from the provider relating to staff training, safe recruitment, medication records and testing for COVID-19. We also spoke over the telephone with one person's family member.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our previous inspection the provider and registered manager did not have effective oversight of risk as part of people's care planning and risk assessment process. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the care planning and risk assessment processes had improved. However, in the management of risks relating to COVID-19 enough improvement had not been made and the provider remained in breach of regulation 12.

- The provider had not arranged for the use of rapid lateral flow tests (LFT) for COVID-19 by staff members twice a week in line with government guidance. LFT tests give a rapid indicator of the presence of COVID-19 and enable providers of social care to respond quickly if needed to help keep people safe.
- There was a system in place to test staff once a week and people living at the home every 28 days; using a polymerase chain reaction (PCR) test for COVID-19. There were records available for recent weeks. However, the provider did not have a track record of using PCR tests. The records provided showed that PCR testing was sporadic and incomplete.
- The provider had not ensured that testing for COVID-19 was taking place at the home in line with government guidance. The COVID-19 risk assessment for Hilbre Manor had identified that regular testing for COVID-19 was needed to control risks.
- Following our visit, we urgently raised our concerns and required an action plan along with assurance from the provider that COVID-19 testing in line with government guidance and their own risk assessment, would take place.

The provider had failed to take reasonable steps to mitigate the risk of COVID-19 at the home. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At our previous inspection people's risk assessments and associated care plans did not always reflect the risks when caring for a person. At this inspection, risk assessments in place to monitor people's safety and wellbeing had been recently reviewed, updated and now reflected the risks present when caring for a person.
- The home's fire risk assessment had been recently renewed by an appropriate person. Each person had a personal emergency evacuation plan (PEEP) which had been recently reviewed.
- A series of checks had taken place with regards to the safety of the building and equipment used.

Staffing and recruitment

● The requirements for the safe recruitment of staff who carry out regulated activities in social care are laid out in law. The provider had failed to ensure that robust systems were in place to ensure the safe recruitment of staff and that the legal requirements were consistently met.

● The provider was unable to demonstrate that thorough checks had taken place on applicant's previous conduct in health and social care settings.

The provider had failed to ensure that robust safe recruitment practices were in place at the home. This is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The rota system in place showed a consistent level of care staff to meet people's needs.

● The rota did not consistently demonstrate how domestic or laundry duties were allocated and the care manager having allocated time to fulfil their management role. The provider told us one member of the care team changed roles at 2pm to undertake domestic work in the home. We observed however, that they remained providing care throughout the afternoon as people required their support.

We recommend the provider review staffing levels and the deployment of staff to ensure necessary supporting roles were fulfilled.

Using medicines safely

At our previous inspection the registered manager had no oversight of the safe use of as and when required (PRN) medication. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This had improved and the use of PRN medication for anxiety had greatly reduced. Protocols for and records demonstrating the safe and effective use of PRN medication were now in place. However, in other areas of medication administration enough improvement had not been made and the provider was in breach of regulation 12.

● The provider could not evidence that all staff who were administering medication had received appropriate training and had their competencies assessed to ensure that they were safe to do so. The providers own medication audits for three months had highlighted that not enough staff members had received the relevant medication training and had their competencies assessed in administering medication.

● Covert medication (hidden in food or drink) was given as authorised by a person's GP and discussed with their family members. However, the person's care plan did not reflect this and did not contain guidance for staff on how to safely prepare the person's medication. There was no record that the person's capacity to make decisions in relation to their medication had been assessed. There was a contradiction between staff administering medication and care records as to whether consent was obtained or not.

The provider had not ensured that robust procedures and systems were in place for the safe and effective administration of medication. This remains a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a recently reviewed medication policy in place. Each person had a medication profile which included the person's photo and information about their medication and any allergies. There was a system in place for weekly stock checks and daily counts of medication.

Systems and processes to safeguard people from the risk of abuse
At our previous inspection the policies and systems in the home designed to safeguard people from the risk of abuse were not being followed. The registered manager and provider had failed to share information and candidly engage with the local authority safeguarding teams. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Since our last inspection staff had received safeguarding training and the systems in place to record safeguarding concerns had shown recent improvements. These improvements need to be sustained and built upon to ensure that cultural change at the service is embedded.

Preventing and controlling infection
● Staff were not always wearing face masks that met the criteria for use in health and social care environments. We also had a concern raised with the CQC that staff had not been consistently wearing face masks in line with government guidance.

We recommend that the provider review the safe use of face masks, to ensure this met the guidelines for health and social care environments during COVID-19.

● The homes environment was clean and well-maintained. At the entrance to the home there was information on COVID-19 safety, antiseptic hand gel and personal protective equipment (PPE) was available. Stocks of personal protective equipment (PPE) were available for staff at convenient locations throughout the home and staff had received training in infection prevention and control procedures.
● Cleaning records were in place for daily, weekly and monthly tasks, including periodic deep cleans of people's bedrooms and equipment used. However, some days there was no allocated cleaner on duty. The provider told us that a staff member would complete cleaning tasks in the second half of their shift. We expressed concerned regarding how often frequently contacted surfaces at the home would be cleaned on these days. Following our visit, the provider reintroduced a record of the cleaning of frequently contacted surfaces.
● In line with government guidance, new visiting procedures had been introduced and systems were in place to ensure these took place safely.
● People had been supported to take part in the vaccination programme.

Learning lessons when things go wrong
● There had been recent improvements in the systems for recording and ensuring appropriate action and learning took place after an accident or incident. However, for several months following our last inspection these audits continued to be of poor quality. The recent improvements need to be sustained and become imbedded within the practice and leadership of the home to demonstrate a learning culture.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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
At our previous inspection the provider and registered manager had failed to ensure the systems in place to monitor the quality and safety of the service were robust and effective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there had been some recent improvements in specific areas of the service. However, these were not embedded and there remained significant shortfalls in the quality of the service being provided. At six of the previous seven inspections dating back to 2015; Hilbre Manor has been in breach of Regulation 17, good governance. The provider over time, with different management structures in place has not been able to provide effective leadership, management and governance at the home for any sustained period of time. The provider remains in breach of regulation 17.

- At this inspection there was no registered manager in place. Following our inspection in July 2020 we took enforcement action to cancel the registration of the registered manager. The provider made alternative arrangements to provide leadership and oversight for the service; however, these arrangements only lasted a short period of time. At this inspection the provider had another temporary arrangement in place and told us that they had plans to appoint another manager.
- Following our inspection in July 2020 the registered manager and provider had shown some resistance to addressing the concerns highlighted. The provider did not have oversight of the work of the registered manager who had been in place. The systems in place for oversight of the safety and quality of the service continued to be poor for a number of months; some concerns had only recently been addressed and remained in place.
- There had been some very recent improvements in the safety and quality of the service being provided. However, these improvements were not embedded, and the service was again in a period of instability.

Following our inspection visit, we asked the provider for an action plan to address some of the immediate concerns from our inspection and to provide a credible plan for the leadership and governance of the service going forward.

There had not been sufficient, sustained improvements in the oversight of the safety and quality of the service being provided for people. This is a continued breach of regulation 17 (Good Governance) 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

● People at the home told us the staff listened to them. One person told us, "I like this home; they look after me well."

● Staff interactions with people were kind and pleasant. However, there were indications of a routine led culture that did not empower people and promote individual choice.

● There had been an improvement in using partnership working with stakeholder organisations to improve the care and support that people received at the home. This had been prompted by the local authority and other stakeholder organisations. The provider needs to build on these relationships and access this support that will benefit people.

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

● There was a long-standing pattern of the provider failing in their obligations to ensure appropriate information was shared. In our last report we stated that the previous registered manager was not candid in his communication. The previous registered manager was recently removed from their position by the CQC. Sufficient time had not elapsed since this happened to establish the providers current practice of information sharing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● When we visited the government had recently approved visits to care homes by a nominated friend or family member. These visits were taking place in a safe manner, in a designated area making use of PPE and appropriate testing.

● There provider had a new system in place for obtaining feedback from people and their family members about the quality of the care provided at Hilbre Manor.

● Family members told us that they would have benefitted from more interaction with staff at the home during the period of COVID-19. One family member told us there had not been much interaction, but what interaction they did have was good. They added, "The care seems really good."

Continuous learning and improving care

● For the previous seven inspections the overall rating for the service has been requires improvement or inadequate. There are repeated themes across multiple inspections showing that the provider does not have robust systems to monitor the safety and quality of the service being provided for people. This does not demonstrate a culture of learning and improvement.

● The registration of the previous manager was removed by the CQC. During this time the provider had allowed the failings within the service to continue; despite being made aware of these failings by the CQC.

● People's care plans had been reviewed and updated in partnership with people, their family members and staff. People's care plans now reflected the care and support that they needed.

Working in partnership with others

At our previous inspection the provider and registered manager had not sought and acted on feedback about the services being provided for people; in order to evaluate and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improvement in this area had been made at this inspection. However, in other areas of governance the provider remains in breach of regulation 17.

● There has been a recent period of engaging with the support being offered by the local authority and other key organisations.

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 had failed to take reasonable steps to mitigate the risk of COVID-19 at the home. The provider had not ensured that robust procedures and systems were in place for the safe and effective administration of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had not been sufficient, sustained improvements in the oversight of the safety and quality of the service being provided for people.

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 failed to ensure that robust safe recruitment practices were in place at the home.