Hilton Residential Homes Limited

Leahurst

Inspection report

Coronation Drive, Widnes, WA8 8AZ
Tel: 0151 495 1919

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection on 12 November, 1 and 2 December 2015.

We completed an unannounced comprehensive inspection of this service on 30 April 2015 and found the provider was failing to meet legal requirements. Specifically the provider had breached Regulations with regard to person centred care, dignity and privacy, cleanliness and infection control, governence and staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with two warning notices and three requirements stating that they must take action.

We undertook a further unannounced comprehensive inspection on 12 November, 1 and 2 December 2015, as part of our on-going enforcement activity and to confirm that they now met legal requirements but we found continued breaches of legal requirements. We found the service had improved in relation to cleanliness and a person had been employed to complete cleaning duties. However, it had not made sufficient improvements in; person-centred care, good governance and supporting staff and remained in breach of these regulations.

At our visit of 1 December we found two staff on duty to support the seventeen people who live at the home. One staff member had to cook meals for people as the cook had rung in sick.

Summary of findings

Following our last inspection and as a result of visits by Halton council contract monitoring team had suspended placements. Other local health care providers had also taken the view that people were at risk from unsafe care and treatment and had suspended placements.

Leahurst provides acommodation for 26 adults with mental health needs. There are two buildings, the main building which has a separately accessed first floor three bedroom flat at the rear and the lodge a three bedroom detached property which is in front of the main building. The flat and the lodge have their own kitchen, bathroom and living areas.

There was a registered manager in place at the home, however they had been suspended from duty since 15 October 2015 . 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider visited the home on a daily basis but we found there were no robust management structures in place at the home. Audits of medicines and care plans were limited in depth and were not effective at identifying issues.

There were 17 people living at the home on the day of our visit. We spoke with people living at Leahurst and they said they were "OK " and felt supported by staff.

The main fire safety risk assessment had been updated and there were Personal Evacuation Emergency Plans (PEEPs) in place so that staff would know the best way to help people evacuate the building in the event of an emergency. Work requested to be carried out at the home by the fire safety officer was proceeding.

During this inspection we found the registered provider failed to mitigate risk to the health and wellbeing of people as risk assessments were not robust. They did not identify the risk or the control measures to reduce and manage the risk. We found risk assessments for people living at the home had not been been improved since our last visit and two people were putting themselves in a vulnerable position in the community and this was not risk assessed and measures were not in place to support these people.

Care plans did not provide staff with sufficient detail on strategies to follow to provide people with the care they needed.

People were not protected against the risks of receiving care that was inappropriate or unsafe because care was not planned and delivered to meet their individual needs or ensure their safety and welfare.

Staff training was underdeveloped with large gaps in the training of staff particularly around the Mental Capacity Act and Deprivation of Liberty Safeguards and mental health needs.

We also found the registered provider had failed to display the most recent rating by the Commission of the service providers overall performance. Discussion was held with the registered provider and he stated he was unaware that the rating must be displayed.

This is a breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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Summary of findings

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.

We found that action had not been taken to improve safety for people who use the service.

We found that personal risk assessments had not been updated to ensure people were supported when risks were identified.

Personal Evacuation Plans had been updated so staff would have a clear understanding of how to ensure people's safety in an emergency situation.

Domestic staff were now employed to ensure the home is cleaned to a high standard.

Is the service effective?

Inadequate

The service is not effective

We found that action had not been taken to improve effectiveness for people who use the service.

Staff had not received updated training with regard to Mental Capacity Act and Deprivation of Liberty Safeguards so that people were not being assessed with regard to capacity to consent to care and support.

Staff received on line training in some key areas of practice, however there was no evidence to confirm that training was effective and had improved the way people were supported. Staff had not received training with regard to mental health.

Supervision sessions were not being held as there was no management structure in place.

Is the service caring?

Requires improvement

The service was not caring

People did not receive person centred care.

When personal hygiene was carried out this was not recorded

Staff were not trained in end of life care.

Is the service responsive?

Inadequate

The service was not responsive

Some activities were taking place and these were being recorded.

Care plans and assessments were not always accurate which resulted in people receiving care which was not tailored to meet their individual needs.

Summary of findings

One residents meeting had taken place but minutes were not available.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager had been suspended and there were inadequate measures in place to ensure that the service was being appropriately managed.

The assessment and quality monitoring systems had not been improved so the care provision was not being appropriately reviewed and improved.

Risk assessments were not completed as required.

Staff were not supported to fulfil their role safely.

Leahurst

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 planned to check whether the provider is 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 an unannounced comprehensive inspection of Leahurst. This inspection was carried out to check whether improvements to meet legal requirements by the provider after our inspection on 30 April 2015 had been made.

The inspection was undertaken by one adult social care manager and one social care inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with seven people who used the service, the registered provider, four staff on duty on the three visit days, looked at the care records for six people, medication and care plan audits and staff training and supervision records.

Inadequate

Is the service safe?

Our findings

During the comprehensive inspection on 30 April 2015 we found the service was not safe. This was because the provider had not protected people against the risks associated with unsafe or unsuitable premises because of inadequate risk assessments and checks on people living at the home who smoked in their bedrooms. We found that there were no Personal Evacuation Emergency Plans (PEEPS) completed for each person so staff would potentially not know the best way to help people evacuate the building in the event of an emergency.

Following this inspection CQC contacted the fire safety officer who visited the home and requested the registered provider took urgent action to improve fire safety at the home and to update all fire safety risk assessments.

On the visit on 12 November 2015 we found that Personal Evacuation Emergency Plans (PEEPS) were now completed for each person. These are essential so staff have a clear understanding of how to ensure people's safety in an emergency situation.

The environment fire risk assessments had been updated and had been seen by the fire safety officer who was satisfied these were to the required standard. Work required by the fire safety officer was in progress but had not as yet been completed.

At the visit on 30 April 2015 we found there were no staff employed to specifically deal with cleaning and laundry, nor, were there any staff employed to act as activities co-coordinators or catering assistants. The home was not being cleaned to a good standard and people were at risk of poor infection control as measures were not in place to minimise this risk.

During the visit on12 November 2015 we found further visits by the infection control team had been made and areas had improved and measures such as liquid soap, paper towel dispensers and pedal bins with lids were now in place. Staff had received some infection control training and a specific staff member was responsible for liaising with the infection control team.

We also found a staff member had been employed to complete cleaning duties and the home was clean and fresh. A cleaning schedule was in place and was being completed by the domestic staff member.

It was identified in the inspection of 30 April 2015 that risk assessments were not specific or individual, nor did they identify the support needed to manage risks to people living at the home.

During the visit on12 November 2015 we found risk assessments in relation to people within the care plan files and had not been updated. The information did not robustly and clearly identify risks, nor was there a clear record of the measures staff were to follow to minimise risk to the person, themselves or others. For example, two people who lived at the home were putting themselves at risk by exhibiting inappropriate behaviour whilst out in the community. There were no detailed risk assessments in place to mitigate or limit these risks. There was no recorded evidence that staff had discussed with the people living at the home the risks of their behaviour or to support the people in case of harm or risks to people in the community. This meant the registered provider had failed to mitigate risk to people living at the home.

This is a continued breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We reviewed the action plan the provider sent to us following our comprehensive inspection in April 2015. We found some of the assurances the registered provider had given had been met but with issues with regard to risk assessments in the action plan had not been met.

Inadequate

Is the service effective?

Our findings

During our comprehensive inspection on 30 April 2015 we found the service was not effective.

This was because the registered manager and provider had not considered the implications of the Mental Capacity Act 2005 (MCA) on people who lived at the home. Staff we spoke with were not fully aware of the principles of MCA or how this affected people who lived at the home.

During the inspection of November and December we found that no improvements had been made and the registered provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA). 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments had not been carried out at all for people to assess their capacity to make decisions about their care, support or safety. This showed that the registered provider had no understanding of the principles of the MCA.

We found there were no decision making care plans for two people who were restricted to leaving the home unaccompanied. This was discussed with the registered manager and registered provider at the visit in April but no capacity assessments had been undertaken when we returned to the home on November/ December 2015.

We found that at least one person had not been assessed as to their ability to manage their own financial affairs. An allocated amount of money was given to this person daily as it was felt they would spend their money inappropriately if it was given to them. We found no records of discussions held with the person, their family or their social worker as to how this decision had been made. On speaking to this person they told us they wanted to have control over their own finances.

Two people who lived at the home were putting themselves at risk in the community. There were no risk assessments in place to mitigate these risks or to support the people if things went wrong.

We found at this visit that staff had not received any updated training with regard to MCA and DoLS.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training certificates seen showed that staff had received training via social care TV, an internet based provider. Training had taken place in safe administration of medicines for eleven staff members, fire safety training for eight staff, food hygiene for the cook, person centred care for three staff members and record keeping for two staff. Although some limited training had taken place there were no methods in place to check and assess the competencies of staff following the training to ensure the learning had been put into practice. Training had not been accessed to support people with mental health issues. The home was registered to care for people living with a mental health illness.

At our visit in November and December 2015 we were informed that the home had no internet access so further training was unable to be accessed.

The provider sent us an action plan telling us what they would do to correct the issues we found at the inspection in April 2015. Although we found some improvements we concluded the training provided was not sufficient to support staff to deliver effective care.

Prior to the registered manager being suspended three staff members had received formal supervision. However there were no plans in place to support staff with supervision as there was no management structure in place.

This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

We found at the inspection in April 2015 that people were not treated with privacy and dignity whilst receiving their medications. At this visit we found that there had been some improvements in the way medication was administered.

The people spoken with said they were happy ling at Leahurst and that staff were " good and friendly".

Since the last visit in April one residents meeting had been held but there were no minutes taken so the wishes of the people who were living at Leahurst were not recorded.

.Staff had worked at the home for many years and knew the people they cared for very well. They appeared to have good relationships with people and interactions were positive.

At the inspection in April 2015 we found that person centred care was not evident in this home. Although we did observe some kindly treatment of people which was well meant, overall the care was institutionalised and representative of old fashioned and out dated practices. At this visit we found that these outdated practices were still evident.

We observed some people had been offered the support they needed to complete their personal hygiene and to wear clothes that fitted them well and were clean. We did however observe people who were not clean and fresh and people who were wearing clothes that were ill fitting. One gentleman wore clothes that were dirty and ill fitting. No one assisted him to change or appeared to find it necessary to encourage him to wash or change his clothes.

Care plans did not record when people had baths or showers so it was not known when people last had a bath or shower to maintain a good standard of hygiene.

There was no evidence that people had been involved in developing their plan of care. People had not signed to agree to their plan of care and reviews generally documented 'no change' indicating that no discussion had taken place with the person about any changes

The care records shown to us did not contain an end of life care plan that reflected the person's wishes or that was in line with published good practice guidance about end of life care. Staff had not received any training with regard to end of life care and support.

Inadequate

Is the service responsive?

Our findings

People we spoke with said they did not have their requests listened to. One person had a review of their care plan in June. It was recorded that they did not have enough activities and wanted to discuss the possibility of a pool table in the home and a TV in their bedroom. They also said they would like to discuss how much money they had but this had not been facilitated. There was no further discussion or records as to why this person had not had his wishes explored.

People spoken with said they liked living at Leahurst.

During the comprehensive inspection on 30 April 2015 we found the service was not responsive.

This was because care was not assessed, planned or delivered in a person centred way. Care plans were difficult to follow and did not contain detailed information to enable members of care staff to know how the person should be supported. We found limited information about people's preferences, and life histories. In addition to this care plans were not being followed by care staff and we did not see any evidence of people or their families being involved in the development of people's care plans or reviews. Daily records were repetitive and did not give any indication as to what the person had done that day.

The provider sent us an action plan to tell us what they would do to put this right. However, at the inspection in November and December 2015 we did not see any improvements in care planning. Although some new care plans had been commenced these had not been completed. The care plans in place still lacked specific strategies for staff to follow, there were discrepancies in information and they had not been updated to reflect up to date care and support of people living at Leahurst.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The home had not employed an activities co-ordinator, however, as there were less people living at Leahurst staff had more time to engage with people and some activities were taking place. For example, chair exercises bingo, large floor board games and film nights.

Staff informed us that people had been out for a lunch to a local pub and people we spoke with said they enjoyed this .There were still no plans to take people on holidays or for days out.

One residents meeting had taken place before the registered manager was suspended. We did not see the minutes but a sheet had been produced asking each person if they would attend and people had signed to agree to attend or to decline.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 30 April 2105 We found there was no robust or effective system in place to ensure the effective management of the service. There were no effective quality assurance or audit systems in place to assess, monitor and improve the quality and safety of the service.

The provider sent us an action plan telling us what they would do to correct the issues. However, during our visit in November and December 2015 we did not see any improvement in quality assurance or audit systems in place.

We saw limited audit forms on care plans which did not include who had been assigned tasks to complete nor a time frame for completion.

Medication audits were confusing and limiting in depth and had recordings such as “yes” and ”no” which made little sense and were not effective at identifying issues.

Since the last visit the registered manager has been suspended and there was no robust management structure in place to ensure that the home was well led. The service did not have effective leadership in place.

The registered provider visited the home every day; however they lacked the management skills and competence to manage the service safely and effectively.

We could not be assured action was taking place to address the wide ranging concerns we reported on at our last inspection. This meant we could not be confident the issues would be

resolved. There was nothing to assure CQC changes would be implemented and people would receive a good standard of care.

This is a continued breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found the registered provide had failed to display the most recent rating by the Commission of the service providers overall performance. Discussion was held with the registered provider and he stated he was unaware that the rating must be displayed.

This is a breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.