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# Hilldales Residential Care Home

## Inspection report

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Tel: 01271865893

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09 March 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Is the service effective? | **Requires Improvement** |

# Summary of findings

## Overall summary

This focussed inspection took place on 9 March 2015 and was announced. We gave the provider short notice of our visit as we wanted to ensure they would be available to provide us with the information we required.

Hilldales Residential Care Home is a large three storey building, originally built as four houses around the turn of the twentieth century. Modifications have been made so that the properties are interconnected internally. There are communal areas on the ground floor and bedrooms on all floors of the building. Externally there is a paved area to the front of the houses and small yards to the side and rear which people have access to.

The home provides accommodation and personal care for up to 56 adults who have needs arising from drug, alcohol or mental health problems.
The service was previously inspected in September and October 2015 when the service was rated as inadequate overall. At that inspection we found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the provider not having adequately trained staff place to protect people from the risk of fire; a lack of suitable systems in place to protect people from unsafe management and administration of medicines; a lack of systems to ensure people were protected from the risk of financial abuse; people's needs and risks had not been fully assessed and care plans did not describe how to support people; people who lacked mental capacity to make particular decisions were not protected, people were being deprived of their liberty without appropriate Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place, some areas of the home and practices posed infection control risks and there were a lack of systems to assess and monitor the quality of the services provided.

After the inspection, we reported that we were taking further action, which included placing the service 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. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

At the inspection in September and October 2015, we found best interests decision-making had not been undertaken to confirm the actions were in a person's best interests. People had signed to give consent for staff to undertake action, for example where staff were managing people's money. However there was no evidence that where there were concerns about the person's capacity to understand what they were signing, this had been assessed.

At the inspection in September and October 2015, we found the provider and the staff were not able to demonstrate they understood their responsibilities in relation to the MCA. The provider and staff did not show an understanding that lack of capacity may not be a permanent condition or that assessments of capacity should be time and decision-specific. They did not understand that people, who have not been assessed to lack capacity to make a particular decision, have the right to make what others might regard as an unwise or eccentric decision.

We served a Warning Notice on Hilldales in respect of a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The warning notice stated there was no evidence of how staff had assessed people's ability to give consent to decisions about their care and treatment. Care plans did not incorporate the two stage assessment of capacity as required by the Mental Capacity Act (MCA) 2005. The warning notice required the provider to become compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 January 2016.

At this inspection, there were 34 people staying at the home, all of whom had lived at Hilldales Residential Care Home for a number of years.

We found the service had undertaken some work towards addressing the concerns identified in the warning notice. People's capacity or otherwise to consent had been considered. There were records for most people which included assessments of people's capacity to manage their own finances and manage their own medicines. However staff had not always put taken steps to ensure that people who did not have capacity to manage their own money were protected from the risk of abuse.
Where appropriate, people's lack of capacity to consent to care and treatment had been recorded. However, the assessments had not provided sufficient detail about what aspects of their care they did not have capacity to make a decision about.

Staff had completed some training about the Mental Capacity Act (2005). However staff were not able to fully describe what impact this might have on people.

We found a continued breach of the regulations of the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service effective?

**Requires Improvement**

The service was not effective.

Although staff had received some training in the Mental Capacity Act 2005, they were not able to fully describe what this meant for people in the service.

Mental capacity assessments had been undertaken in respect of people's ability to consent to care and treatment. However it was not clear from the assessment what aspects of care and treatment, people were or were not able to consent to.

Where people were identified as not having capacity to manage their own finances, there were not adequate systems in place to ensure they were protected from abuse.

# Hilldales Residential Care Home

**Detailed findings**

## Background to this inspection

We carried out this focussed 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, and to check whether the provider had taken action to address the breach of regulation 11 identified at the last inspection. The provider had been served a warning notice in December 2015 which had required that the service became compliant by 31 January 2016.

This inspection took place on 9 March 2016 and was announced. The inspection team consisted of two inspectors.

We spoke with the provider and six members of staff. We reviewed six people's care files, staff training records and certificates. Prior to the visit we spoke with a member the local authority's Deprivation of Liberty Safeguards team.

Requires Improvement

# Is the service effective?

## Our findings

At the inspection in September and October 2015, we found a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. We found evidence that the Mental Capacity Act (MCA) 2005 was not being followed when complex decisions needed to be made such as whether a person was able to understand and retain information relating to their finances. There was no evidence that a best interests meeting or decision-making process had been held or best interests decisions made for people without capacity. Where staff had a concern that a person did not have capacity, no capacity assessment had been completed.

The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. When people are assessed as not having the capacity to make a decision, a best interests decision is made involving people who know the person well, such as relatives or friends, and other professionals, where relevant.

Where people are deemed to not have capacity to make a decision about a particular issue, it may be necessary to consider whether they are being deprived of their liberty in relation to the issue. If this is found to be the case, at the same time as an application for a Deprivations of Liberty Safeguards (DoLS) authorisation must be made, the provider must do all they can to find less restrictive ways if possible to meet the person's needs. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

At the September and October 2015 inspection, there had been applications made for seven DoLS authorisations, which were waiting to be assessed. However, here was no evidence that staff had updated care records to reflect the DoLS applications. At that inspection, staff were unable to evidence what processes they had undertaken and were not able to describe how they had arrived at the decision that a DoLS application was needed. No assessment had been undertaken to determine people's mental capacity to manage their finances. There was no evidence that where a person did not have capacity in financial matters, the home had considered whether an appointee or deputy was needed for that person.

An appointee is responsible for managing a person's benefits and a small and limited amount of savings in case of unforeseen circumstances and paying bills and managing money if the person has smaller assets. A deputy is a person appointed by the Court of Protection to be legally responsible for someone who lacks capacity to make decisions for themselves where there is no power of attorney. A deputy undertakes responsibility for the management of all of a person's financial affairs if they become incapable of doing so themselves including savings, pensions and all sources of income or assets including property and valuables. All the duties of an appointee are also the responsibility of a deputy if one is appointed.

At this inspection, a senior member of staff said they had undertaken mental capacity assessments with the majority of the people living at Hilldales. They said they were transferring care information into a new

record format. As part of this process, they said they were assessing people's capacity to consent to care and treatment. They were not able to explain what specific decisions they were assessing people's capacity to make. They were not able to explain what had led them to assess everyone rather than individual people, where they had identified a particular concern. They also said they were assessing people's capacity to self-medicate and to manage their own finances. The senior care worker said they had five more records to complete in the new format. They described how they asked questions which related to a person's ability to understand issues such as how to handle money. Staff repeated the process after a short period of time to see if people gave consistent answers to show they understood.

An application for a DoLS authorisation for one person had been sent in May 2015. At the time of this inspection, this had not been assessed by the local authority. Prior to this inspection, we had spoken to a member of staff in the local authority DoLS team, who had reviewed the application and said that it had very little detail in it and therefore it had been assessed as a lower priority than others received. At this inspection a senior care worker said a new DoLS application for this person had been submitted to the local authority during the week of the inspection, in respect of the person's mental capacity to be able to go out on their own. Care records confirmed this. A Mental Capacity Act – Best Interests checklist had been completed for this person in February 2016. This described how the person was at risk as they had been known to fall and injure himself when out alone. It also described how the person 'can get lost from time to time' and how the person was not 'very road safe when [person] leaves the home.' It described how the proposed intervention was 'applying for a depravation of liberty safeguarding (DOLS) as part of the care we provide for [person] is that he will leave the home of his own accord and Hilldales have to go to collect [person] to return him to the home for his own safety'.

A senior care worker said the person was monitored by staff, but at times, left the home unaccompanied without staff being aware of this. Staff described how they checked to see where the person was on a regular basis and monitored when the person left the home. However, daily notes showed on two occasions during February 2016, the person had left the home on their own. On one occasion the notes described the person being brought home by an off-duty member of staff, on another occasion the notes described the person as "very confused" when they were brought home by a member of staff. There was no evidence that the risks to the person had been reassessed following these incidents or that any change to the care plan had been considered.

In five of the six care records reviewed there was a mental capacity assessment in respect of care and treatment. However these did not describe adequately what was meant by care and treatment. We discussed one of these assessments with senior care workers. The assessment had identified that the person did not have mental capacity to give consent to care and treatment. We asked whether the person was able to make any decisions about their care, for example whether to have a bath or a shower. Staff said the person would be able to choose between limited options, and would understand the purpose of a bath. The staff member also said that the person was not resistant to personal care. This meant that there were aspects of care and treatment where the person was able to make choices and give consent to their care. This showed staff needed further support with understanding the assessment they were completing.

One person had been assessed by a senior member of staff in January 2016, as not having capacity to manage their own money. We reviewed an assessment of their capacity to understand the management of their finances. There was no evidence that, following this assessment, staff had involved health or social care professionals, for example the person's local authority care manager. This involvement would have helped ensure best practice was followed. For example, a review of any recent concerns relating to the person's capacity around a specific issue and a best interests meeting or other process involving the person, family, staff and health and social care professionals.

The front page of the person's care plan dated 4 February 2016 stated 'I also had a mental capacity assessment on management of finances at Hilldales, this also states that I have been deemed to lack capacity.' Staff had completed a risk assessment on the 9 February 2016, which described the level of risk as high. It stated that the person had been referred to the Court of Protection to manage their finances. The risk assessment described the measures that had been put in place to protect the person. These included keeping the person's cheque book locked in the home's safe and 'Hilldales will also purchase and pay for any items [person] requires to meet his needs.' A senior care worker described how they had contacted the local authority to discuss the person's need for a Court of Protection deputy. However we found evidence although the person had been assessed as lacking capacity, staff had requested the person to sign a cheque for over a £1000,. This showed that staff did not fully understand what they needed to do when a person had been assessed as lacking capacity.

Correspondence from the local authority who commissioned the care for this person indicated that the person did not have to contribute to their residential fees. However there was no evidence that this had been discussed with the person or their representative. The provider and staff were unclear what impact this had on the person, for example whether he was entitled to a refund.

We discussed with the provider what systems were in place to record the personal allowances received by the provider from local authorities for people living at the home. We expressed concern the system was poorly managed. For example, a person did not have the correct support to manage their finances. Their most recent care plan was dated November 2009 and described how a condition of their stay was that the management team would manage their finances on their behalf. We checked their financial records and saw they owed the provider £1500, which left them in debt. An assessment of the person's capacity to manage their finances had only been completed in January 2016.

The provider said the person "was not allowed to know how much money he had." This contradicted a member of staff who told us they would tell people how much money they had if they asked. Following our discussions, senior staff said they now recognised they would need to discuss an application to the Court of Protection for this person.

We asked whether each person was provided with information about how much had been received on their behalf and what the balance of their money held was. We also asked whether the provider had investigated alternatives to the present system whereby all money was paid into the provider's business account. The provider said this had not happened. A senior care worker said they would investigate, with the involvement of local authorities, alternative arrangements for people's finances. We had first raised this concern at the inspection completed in December 2014 and January 2015. We raised this concern again at the inspection held in September and October 2015. We also asked whether people's money, held in and paid out of the business account, was checked and audited, with information provided to each person. The provider said staff audited the records of incoming and outgoings but information was not routinely provided to individuals about their balance.

Staff had completed a three hour training session which staff said provided an introduction to safeguarding vulnerable adults and the MCA in February 2015. Senior staff were positive about the training, but recognised they needed more support in their learning. They said the training had not covered DoLS. They said they recognised that some of the previous DoLS applications submitted to local authorities had not been appropriate. They described the assessment of people's mental capacity as a "huge responsibility." Senior staff said they were planning to complete further training, which would include training about DoLS.

None of the staff we spoke with could confidently describe what the purpose of MCA and DoLS or how they

would apply requirements of the legislation to the care they provided to people living at Hilldales.

This meant that there was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>Mental capacity assessments had been undertaken in respect of people's ability to consent to care and treatment. However it was not clear from the assessment what aspects of care and treatment, people were or were not able to consent to.<br>Where people were identified as not having capacity to manage their own finances, there were not adequate systems in place to ensure they were protected from abuse. |

**The enforcement action we took:**

continue warning notice