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 lift access. At the time of our inspection 13 people were living at the home.

People's experience of using this service and what we found
The policy and systems in place at the service, designed to safeguard people from the risk of abuse were not being followed. The registered manager and provider had not always ensured appropriate safeguarding alerts had been raised and the registered manager had not candidly engaged with social workers who investigated safeguarding concerns.

The monitoring of people's safety and wellbeing remained ineffective and people's risk assessments and associated care plans did not always reflect the risks present in their care. Plans and checks in place to help ensure people were safe in an emergency, the monitoring of people's falls and monitoring the safe use of medication were inadequate.

There was often a failure on behalf of the provider and registered manager to acknowledge, learn and make improvements when events went wrong within the service. The systems in place used by the registered manager to have oversight of the safety and quality of the service were inadequate.

The provider and registered manager operated the home as a closed culture, they had resisted information sharing and engagement with stakeholder organisations.

The provider and registered manager had failed to ensure they had informed the CQC of information where they had a legal obligation to do so. The registered manager has also failed to be candid in his communication with the CQC.

There were enough staff present to meet people's needs in a timely manner; the rota system demonstrated there were consistent staffing levels. Care staff were friendly, and we observed them treating people with kindness.
The home's environment was clean and well-maintained.

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 requires improvement (published 1 February 2020) and there was a breach of Regulation 17 (Good Governance). The registered manager completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found there had been a deterioration in the governance of the service; therefore, the home remains in breach of Regulation 17.

This home has been rated requires improvement for the previous six consecutive inspections.

Why we inspected
The inspection was prompted in part by information we received that raised concerns about people receiving safe and effective care. The provider had moved five people into Hilbre Manor from one of their other homes at the end of April at the height of the COVID-19 pandemic, without engaging with partner organisations and against the published advice of Public Health England.

We had become aware of a number of events recently taking place at the home, that had resulted in serious safeguarding concerns being raised. The registered manager and provider have not been candid about these events; they had not reported them to the CQC even though they had a legal obligation to do so.

A decision was made for us to conduct a focused inspection and examine those risks under the key questions of; 'Is the service safe?' and 'Is the service well-led?' Ratings from previous comprehensive inspections for the other key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

The overall rating for the service has therefore changed from requires improvement to inadequate; based on the findings at this inspection.

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

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 pandemic when considering what enforcement action was necessary and proportionate to keep people safe. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

In May 2020 we took urgent enforcement action to restrict new admissions to Hilbre Manor EMI Residential Care Home and restrict the moving of people between this home and another home then owned by the provider, unless they had written permission of the CQC. We took this action because we received information of concern that the provider was planning to move five people into Hilbre Manor from one of their other homes during April, at the height of the Coronavirus pandemic. The moving of people by the provider took place with a lack of communication and transparency, without engaging with partner organisations and against the published advice of Public Health England.

At this inspection we have identified breaches in relation to assessing risk and ensuring people are safe, safeguarding people from the risk of abuse and the provider, notifying CQC of events that they have a legal obligation to do so and the provider and registered manager failing to assess, monitor and improve the safety and quality of the service being provided.

Full information about CQC's regulatory response to the serious concerns found during this inspection will

be added to this report after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We have raised our concerns about this service with the local authority and will work with them to closely monitor the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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 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.

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.

Inspection team
This inspection was completed by three inspectors. Two inspectors visited the home on 23 July 2020 and a third inspector considered information available since our previous inspection in November 2019 and information received from the registered manager following our visit on 23 July 2020.

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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we wanted to make sure arrangements could be made to make sure the inspection took place as safely as possible.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority.

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 the registered manager and three members of care staff. We viewed a range of records. These included five people's care records and multiple medication records. We also viewed a variety of records in relation to the management of the service.

After the inspection
We had a meeting via videoconference with the registered manager and one of his colleagues to ask questions and clarify what we found during our visit. We then provided written feedback to the registered manager and provider; we met again by videoconference with the registered manager to answer any questions they had in relation to the feedback given.

The registered manager provided documents relating to staff training, the safety of the premises and management of the home following our visit.

We raised a safeguarding alert with the local authority relating to the care and support of four people living at the home.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The policy and systems in place at the home, designed to safeguard people from the risk of abuse were not being followed. The information held at the service about safeguarding concerns was inadequate. The registered manager and provider had not ensured appropriate safeguarding alerts had always been raised.
- The registered manager and staff had not followed the home's policy to ensure prompt information sharing took place with the local authority who have the statutory responsibility to investigate safeguarding concerns.
- The registered manager had not candidly engaged with social workers who investigated safeguarding concerns.

The provider and registered manager had not taken action to help ensure people were safeguarded from the risk of abuse. 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.

Assessing risk, safety monitoring and management

- At our previous inspection we found the monitoring of people's safety and wellbeing, had not always been effective. After that inspection the registered manager put a system in place for monitoring the wellbeing of people who stayed in their rooms during the day. This had not been maintained and the records of people's wellbeing remained limited.
- At this inspection we saw people's risk assessments and associated care plans did not always reflect the risks when caring for a person. At times people's care plans contradicted known risks; for example, failing to mention or provide guidance for staff regarding ongoing health concerns. The guidance for staff on what checks, monitoring, or actions that needed to take place to ensure people were safe, was still insufficient.
- At our previous inspection we reported that Personal Emergency Evacuation Plans (PEEP's) were not clear and did not contain the information needed to safely evacuate people. At this inspection, this had not improved. The evacuation plans were incomplete and did not provide enough relevant information for the reader to understand a person's needs. Also, the fire and emergency evacuation plan had not been kept up to date and only six of the 13 people living at the home were included. When we highlighted this, it was quickly rectified by the registered manager.
- Some people were at high risk of falling over and experienced regular falls. The assessing, recording and monitoring of people's falls and action taken to mitigate this risk was inadequate.
- The registered manager's log of falls was very inaccurate and not all falls were recorded by staff as an incident in line with the provider's procedures. This meant the system was chaotic, and the registered manager did not have oversight of people's risk of falling.

● We saw records in people's daily care notes that staff had identified bruises on people. However, the records did not show what action staff, or the registered manager had taken to investigate people's bruises, or if the bruise was of an unknown cause to make appropriate referrals to the relevant authorities.

The provider and registered manager failed to adequately assess and mitigate risks. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The building was safe. The services and equipment in the building had been regularly checked.

Using medicines safely

● There was no oversight regarding the use of as and when required (PRN) medicines. The registered manager could not be assured these were being used safely.

● We checked the records for people who received a PRN medication (a schedule 4 controlled drug). We found stock errors that had not been investigated and a dose of medication had been given that contradicted the instructions on the PRN protocol, which had also not been investigated. There were also multiple examples of medication records showing that when a person received this medication, daily care notes did not reflect this and on occasions directly contradicted the recorded reason for the medication being given. We also saw the opposite where daily care notes recorded PRN medication being administered with no corresponding records of medication stock being used. Records of the administration of PRN medication and the reasons for doing so were chaotic. The registered manager told us that these were recording issues and apparent contradictions were because staff only summarised people's experience of the day in the daily records.

● There were no risk assessments or care plans regarding the use of PRN medication. Some PRN protocols that were available for staff were incomplete and did not offer enough guidance for staff on the use of PRN medication.

● The registered manager told us PRN medication was checked weekly and audited monthly; this was not credible. The records of PRN medication could not enable the registered manager or other senior staff to review people's use of this type of medication, to ensure it was being used safely and to monitor their wellbeing.

Following our inspection, we raised a safeguarding alert with the local authority for three people who receive PRN medication at Hilbre Manor.

The provider and registered manager had not maintained a system to ensure medication was used safely. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was often a failure on behalf of the provider and registered manager to acknowledge, learn and make improvements when events went wrong within the service. When engaging with partner organisations the registered manager was often defensive.

● Learning had not taken place from areas identified during our previous inspection in November 2019. This is the seventh inspection in a row that has highlighted areas requiring improvement at this service.

The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service being provided for people. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were sufficient staff present to meet people's needs in a timely manner; the rota system demonstrated that these were consistent staffing levels.

● The registered manager told us there had been no new staff members recruited since our previous inspection.

● Records provided showed that staff had received training, in safeguarding, moving & handling and health and safety.

Preventing and controlling infection

● The provider and registered manager had put in additional measures to help prevent the spread of COVID-19. Staff had access to and were using appropriate PPE.

● The home's environment was clean and well-maintained.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last 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 breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the oversight of the service had deteriorated; therefore, the provider is still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The systems in place, used by the registered manager to have oversight of the safety and quality of the service were inadequate.
- People's risk assessments and associated care plans still failed to address the risks present in people's care. They had not ensured that an adequate system was in place for checking on the wellbeing of people who stayed in their rooms; and plans to keep people safe in the event of an emergency did not contain enough detail or were not up to date.
- There was no formal process for reviewing accidents and incidents, including people having falls, the use of PRN medication for people experiencing anxiety and ensuring any concerns highlighted by staff members in people's daily records were acted upon.
- Safeguarding records were inadequate and omitted matters that had been alerted to or investigated by the local authorities' social workers.

There remained a lack of 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.

- People's care records were mostly written at the end of a 12-hour shift. Often, they lacked sufficient detail with regard to the care and support provided, along with the decisions made when caring for a person and on occasions omitted important key events from a person's care during the day.

The provider and registered manager had failed to ensure that there was a complete and contemporaneous record of the care provided for each person and a record of the decisions made in relation to their care and wellbeing. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● For the previous six inspections the overall rating for the service has been requires improvement. The rating following this inspection has now deteriorated to overall inadequate. There are repeated themes across multiple inspections showing a lack of 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.

A failure to assess, monitor and improve the service being provided for people is a 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; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider and registered manager operated a closed culture within the home and resisted information sharing and engagement with stakeholder organisations.

● There was a lack of partnership working with stakeholder organisations that provide services that may be of benefit to people living at Hilbre Manor.

● There was a lack of openness and transparency when sharing information about events that had gone wrong at the home. For example, safeguarding concerns were not dealt with in an open and objective way.

● Since our previous inspection the CQC took urgent enforcement action to restrict new admissions to Hilbre Manor EMI Residential Care Home and restrict the moving of people between one of the providers other homes then in operation, without the written permission of the CQC. We took this action in part because of a lack of communication and transparency from the provider and registered manager during the COVID-19 pandemic.

Working in partnership with others

● At our previous inspection we highlighted to the provider and the registered manager that they had not worked collaboratively or engaged effectively with key organisations.

● Since our previous inspection there remained a lack of transparent and collaborative partnership working with external stakeholders and other services. The registered manager has been offered support from the local authority, but they have not effectively engaged with this.

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

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

● At our previous inspection in November 2019 we raised concerns about an emerging pattern of failing to notify the CQC of events when there was a legal obligation to do so. At that inspection we clarified for the registered manager what events required notifying.

● The registered manager and provider have continued a pattern of failing to send information to the CQC that they know they have a legal obligation to do so. Information that has been shared with the CQC since our previous inspection has not always been timely or accurate and at times did not contain key information about the events being notified.

● The registered manager has failed to be candid in his communication with the CQC.

On the previous inspection this had been identified as a breach of the conditions of registration for this service. Due to the COVID-19 pandemic any enforcement action regarding this breach was stopped. This will

now be reconsidered separately to this inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager failed to adequately assess and mitigate risks.

The enforcement action we took:

Cancellation of the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had not taken action to help ensure that people were safeguarded from the risk of abuse.

The enforcement action we took:

Cancellation of the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to assess, monitor and improve the quality and safety of the service being provided for people.

The enforcement action we took:

Cancellation of the registration of the registered manager.