Hilbre Care Limited

Hilbre House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Hilbre House on 19 May 2016. Hilbre House is registered to provide accommodation and personal care for up to 20 people. At the time of our inspection there were 14 people living at the home.

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

During the inspection we found breaches of Regulations 11 and 17 of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

Some of the people who used the service had a diagnosis of dementia which had an impact on their ability to consent to decisions about their care. People's mental capacity had not been assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been applied for.

There were enough staff to meet people's needs and staff received training to enable them to provide care to people safely, however we did not see evidence that every member of staff who worked in the home had completed all of the training.

We observed staff supporting people at the service and saw that they were warm, patient and caring in their interactions with people. People were seen to be relaxed and comfortable in the company of staff. People who used the service and their relatives told us they were happy with the service provided.

The premises were clean and bedrooms were appropriately decorated and furnished. Regular health and safety checks of the environment were not clearly recorded and some people did not have a call bell available to use when they were in bed.

The registered manager did not engage with us during the inspection and there were no other management staff identified on the staff rota. Some quality audits had been carried out but these were not comprehensive. We found no evidence that people had been asked for their views of the service during recent months.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe.

Some people who lived at the home did not have a functioning call bell to use to call for assistance when they were in bed.

There were enough staff to meet people's care and support needs.

Recruitment procedures for new staff were not always robust.

People's medicines were managed safely

Is the service effective?

Requires Improvement

The service was not entirely effective.

People who were living with dementia did not have their legal rights protected with regard to the Mental Capacity Act (2005).

A training programme was provided to ensure that staff knew how to work safely, but we could not see evidence that all staff who worked at the home had attended all of the training.

People enjoyed a good standard of catering.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

People who lived at the home told us that staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's support needs were documented in their care files, but

the care records did not always record details of decisions made.
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People were referred to health professionals and supported to attend medical appointments.

Social activities were provided infrequently.

Complaints received were recorded in detail.

Is the service well-led?

Inadequate

The service was not well led.

The management arrangements for the service were unclear and the registered manager did not engage with the inspection team.

There was no evidence that people living at the home and/or their families had been asked for their views of the service in recent months.

Some quality audits had been carried out but these were not comprehensive.

Hilbre House

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 had addressed breaches of the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 19 May 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we looked at information CQC had received since our last visit. We had received concerns about the service from the local authority.

During our visit we spoke with nine people who lived at the home, one visiting relative and seven members of staff. We looked at the care files for four people who used the service, medication storage and records, staff training and supervision records, accident and incident report forms, health and safety records, complaints records, and other management records.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at Hilbre House if they felt safe and they told us they did. We also asked a visitor if they felt their relative was safe and they replied "Yes, one of the reasons we chose this place. It's great, 24 hours somebody is here if something happens."

Records we looked at showed that staff had received training about safeguarding vulnerable adults, and staff we spoke with were aware of who they should report any concerns to. The telephone number for reporting any issues to the local authority was shown on a noticeboard. One safeguarding referral had been made in February 2016 and one in April 2016, however we had been informed that the local authority had concerns regarding other incidents that had not been reported to them or to CQC. A whistleblowing policy was in place. The administrator told us that no money was held on behalf of people living at the home and additional charges, such as hairdressing, were invoiced.

We looked at accident records for 2016 which showed that four accidents had been reported in January, six in February, 11 in March and none in April. The four falls in January were all by the same person and this had been resolved by the person spending their daytime in the lounge, where help with mobility was always available. Two falls in February related to a person who had been referred to the falls team, and two involved a person who had been incapacitated by a urinary infection. This showed that action had been taken to address the occurrence of falls.

We looked whether the environment was safe for the people living at the home. Current safety certificates were in place for electrical circuits, the fire alarm and emergency lighting systems, gas including boilers, and the passenger lift. Water sampling for Legionella had been carried out in April 2016. We did not see records of portable appliance testing or asbestos testing. We were told that there were no portable hoists in the home.

We observed a number of issues where improvements were needed. There were no window opening restrictors on wooden windows in the conservatory. Although this was on the ground floor, there was a significant distance to the ground if someone should fall. In a number of areas, window closers were loose and some were broken. In one room, a toilet pan had been removed and the soil pipe had not been capped but was stuffed with plastic bags. A room on the first floor containing tins of paint and glue was not locked.

A number of call bells in people's bedrooms on the first floor were not working and incorrect names were written on the call bell control panel. One person told us they would use their telephone if they required assistance. Other people were mobile but would need to get up out of bed if they needed help during the night and may be at risk of falling. The risks to these people of not having a call bell to use from their bed should be assessed.

We saw monthly 'health and safety checklists' for January, February, March and April 2016. Some issues were identified and the action required was 'see plan'. The staff we spoke with were not able to show us what this plan was.

A fire safety file contained a premises fire risk assessment which had been written by the manager and dated 24 November 2015. We did not see evidence to show that the manager was a 'suitably qualified person' to carry out a fire risk assessment. A plan of the fire alarm system was displayed in the entrance hall showing zone maps, break glass, call points and extinguishers. The fire extinguishers had been checked by contractors in May 2016. There were door-guard closers on some bedroom doors so that people could have their door open without causing a fire risk. Records showed that staff had participated in fire evacuation practices carried out by an external company including a simulation of a fire in the kitchen. Detailed evacuation plans for the people who lived at the home were located in a 'grab file'.

We looked all around the premises and found that the home was fresh and clean with no unpleasant smells. Appropriate hand washing facilities and personal protective clothing were provided. Weekly cleaning schedules were in place for housekeeping staff and night staff. Cleaning chemicals were stored appropriately in a locked cupboard. The laundry appeared clean and well organised. The home had a five star food hygiene rating.

We spoke with the care workers on duty and they told us there were two care staff on duty throughout 24 hours, with a third member of staff between 8am and 10am to help people getting up in the morning. This appeared to be enough staff for the current occupancy of 14. The staff rota was difficult to interpret as it did not show people's job roles. The home's service user guide stated 'The home is run by the manager along with the deputy managers', but we were unable to identify who the deputy managers were and they were not named on the current staff rota.

Some staff worked both day and night duties and the rotas showed that sometimes staff worked from 2pm until 8am the next day, a total of 18 hours, which is a very long shift. On the day of our inspection, one member of staff was working from 8am to 8pm and they were also rota'd to work the night shift. They told us that they would not be working the night shift but none of the staff we spoke with knew who would be working that night.

We asked to look at recruitment records for the most recently employed staff. We were provided with two files that were for one member of staff who had started working at Hilbre House in 2015, and one in 2014. They had both completed application forms and had a criminal records check. One of the staff had only one reference on file and this only confirmed their employment between September and December 2011. This was an inadequate check on the person's background before employment to ensure they were safe to work with people who used the service. There were two references on file for the other person.

One of the senior care staff showed us the arrangements for the management of people's medicines. They told us that five senior care staff administered medicines. Medicines were dispensed in a 'pod' system with a description of what each tablet was. Running totals were maintained for items that were not in the 'pods'. The medicines were stored safely in a trolley and a locked cupboard and appeared to be well managed. The senior care worker told us that there was no covert (hidden) administration of medicines. One person looked after their own medication and had been assessed as being able to do this safely.

Requires Improvement

Is the service effective?

Our findings

Records we looked at showed that staff received training about safeguarding, food hygiene, fire safety, medication, moving and handling, first aid, health and safety, and infection control. However, the records available did not provide evidence that all of the staff who worked at the home had completed all of the training. The three care staff on duty all said they had a national vocational qualification (NVQ) level 3 in care. Evidence in a training file showed that moving and handling training was planned for 9 June 2016. We were told that new staff in the organisation were doing the Care Certificate, but none were working at Hilbre House. We saw no evidence that staff had received training relating to supporting people who were living with dementia.

Records showed staff had a bi-monthly supervision meeting, but not all the staff who were named on the staff rota were on the supervision list. Comments written by staff included 'My supervisor listens well to the staff.' and 'My supervisor is very supportive.' We also saw records of seven staff having an appraisal, however the appraisals for the care staff were dated December 2014, January 2015, and March 2015.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Providers are required to submit applications to a 'Supervisory Body' if they assess a person as needing the protection of a DoLS. A recent legal ruling stated that if a person, lacks capacity, is unable to leave unsupervised and is under constant supervision then a DoLS should be considered. We asked to look at DoLS records relating to people living at Hilbre House but were told that there were no DoLS in place.

A list on the noticeboard in the office dated 18 May 2016 recorded that four named people living at the home did not have 'MCA Capability'. In other records we looked at, these people were described as having 'vascular dementia' and a 'high level of cognitive impairment'. One person's grab file entry stated 'lacks capacity to make informed decisions', however we did not see records of people's capacity to make decisions being assessed. Another person we spoke with was clearly confused and told us they were "in a workhouse". This meant that people were living at the home without their legal rights being protected and their capacity to consent had not been explored with regard to the Mental Capacity Act.

This is in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 Need for consent.

At lunchtime we observed that 12 people had their meal in the conservatory and two people had their meal

in their own room. People were offered drinks including alcoholic drinks of their choice. Tables were laid out with napkins, cold drinks and condiments. Dinner was served on silver trays, with gravy in a gravy boat. This meant that people could help themselves to what food they wanted and take as much as they liked. People who could be independent in their eating were encouraged to do so. Staff wore aprons to serve. Some people wore covers to keep their clothes clean, others didn't as necessary.

People commented that the meal was "very nice". One person chose to have sandwiches and these were served with side salad and cut up to be finger food, to help them eat independently. The chef told us that after lunch he would go around and speak to people and check that lunch was OK. He would also find out what people would like to have for tea; there were six options available. He told us that two people had diabetes and described how he catered for this.

A visitor told us that their relative had stopped eating a main meal, but was given soups, sandwiches, and fortified desserts and the person's weight had stabilised. When we looked at this person's care notes we did not see a nutritional risk assessment to identify the level of risk and monitor whether the risk was increasing or decreasing.

Good

Is the service caring?

Our findings

We asked the people who lived at Hilbre House if they liked living at the home. One person said "I'm well supported. I think they are very nice here, very kind." The second person we spoke with told us "I'm well looked after. I can have tea and coffee whenever I want. Of all the places this one is the best." The next person said "They've got good food here, you can have two puddings if you want or more dinner. The carers are very kind to us. They do try their best."

Another person told us "I've got used to it. I'm well cared for and nobody makes you do things. I try not to be bored, I pick up the paper or something." One person said they were "quite content" and the care was "fine", and another said "Absolutely no problems here, rooms are great, staff are great, food is good."

One person we spoke with had a bedroom that had been refurbished and had a nice bright siting area with good views. They told us "It's been a life saver. Della and the staff have been amazing. It's lovely living here. They have made me so welcome. It's such a nice, warm, friendly place. Nothing is ever too much bother."

During our inspection we were able to speak with one relative who was visiting. They told us the home was "In general very good, really happy with it. The chef has been superb, put his heart and soul into it, got great confidence in him." The relative told us they had good communication with the home and they were "notified of things straight away".

During lunchtime we observed positive interactions between staff and people having their meal. People were able to choose what they would like and could take as much or as little as they wanted. People were given the support they needed, but this was done discreetly. The chef told us that one person had asked to have a curry and a beer for their birthday meal and this had been provided.

A service user guide was available for people who lived at the home and their families, however we found that the information contained in it was not always accurate. For example, the service user guide stated that all rooms were 'equipped with a nurse call system, colour television, video and private telephone'. Some bedrooms had telephones but others did not. One person told us they would like to ring their sister and asked us "Can I have a phone in my room, I know their numbers?" We noticed that there was a copy of the day's menu by the visitors' signing in book and there was also a copy of CQC complaints information and the last inspection report.

Requires Improvement

Is the service responsive?

Our findings

People's care notes were recorded on an electronic system and there was also a paper file for each person which showed evidence that people were referred to medical professionals appropriately, for example continence service, falls prevention team, optician, and lymphoedema nurse. People were supported to attend medical appointments. The care files we looked at showed evidence of regular reviews of people's care and support. There was also information about people's personal histories and who and what was important to the individual.

During the inspection we were concerned about a person who had a bedroom on the first floor and did not go downstairs at all, for example to the dining room for lunch. The person's care file recorded that they were 'Usually unsteady on their feet and is at risk of falling while walking or mobilising without assistance.' The high risk of falls had been identified in 2015 with instruction to 'explore downstairs room, wheelchair, O/T referral made'. In the daily care notes, entries stated that the person was wandering out of their bedroom unaided up and down corridors most days, and was confused. The falls risk assessment stated 'encourage [Name] to remain in areas where they can be easily observed', however this was not possible when the person was on the first floor and staff were generally on the ground floor. We were told that the person's family had been consulted but there was no documented evidence of this.

Following our inspection we had contact with a close family member who told us that the person had the same bedroom since they went into the home. A downstairs room had been offered but the family felt 'on balance they would be better staying in their present room'. They confirmed that 'staff do their best to get the person to eat downstairs, but they refuse'. They went on to tell us that the family were 'happy with the level of care they were receiving and the staff are doing their best.'

During our inspection no social activities took place. A member of staff told us that an activities co-ordinator was employed but was off sick. Some people were occupied watching TV, reading newspapers, and one person told us they liked doing crosswords and reading books. They said "There are books all over the house." Another person said "They have got a parasol and garden furniture, we will use this in the summer when it's not windy." People told us they sometimes had quizzes and they enjoyed these. People told us they used to go on "lots of outings" but they had not been out for a while and they thought this was due to a driver not being available. An activities file recorded a singing group on 27 April; chair exercises and quiz on 18 April; Music for Health on 5 April. The records showed that there was an organised activity approximately once a week.

We found a complaints folder in the staff office. The home's complaints procedure was dated January 2015 and was summarised in the service use guide. We saw that seven complaints had been recorded during 2016. Detailed records were maintained which showed that the complaints had been investigated and addressed and an appropriate response made to the person who had made the complaint.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager, who was also the proprietor. The registered manager was unhelpful towards a member of the inspection team and did not engage with us during the inspection. The registered manager stayed in a room with the door closed and did not respond to questions. When we asked to speak with the registered manager during the afternoon, we were told that she had left the premises and "she will not be back today". This meant that we were unable to ask the registered manager for further clarification of some of the issues we found or give feedback to her. The company's training officer, and other staff, helped us with the inspection but were not able to provide all of the information we needed. A member of staff told us "She's stressed; she puts a lot of work into this home."

The service user guide stated 'The home is run by the manager along with the deputy managers' but we were unable to identify who the deputy managers were and their names were not on the current staff rota. Staff we spoke with named two people who they thought were the deputy managers but they were not on duty that day.

A member of staff told us "I like it here, it's like family." and a person who lived at the home said they had "confidence in the manager".

A thank you letter dated January 2016 stated 'We have found the staff to be friendly, approachable and professional. Chef has been extremely accommodating in his efforts to ensure [person's name] continues to have a balanced diet and sufficient to eat. The atmosphere in the home is both friendly and homely and we are made most welcome when we visit.'

Staff meetings had been held on 11 March and 18 May 2016.

We asked for a list of people living at the home and were given a 'residents list' dated 5 April which contained the names of 19 people. A member of staff informed us that there were 15 people living at the home but care staff told us there were 14. A number of different resident lists showed different names and numbers.

We looked at a file titled 'Resident and Family Surveys'. This recorded a meeting on 14 August 2015 where people discussed food, the home environment, and activities. There were four family surveys dated 2014, also a resident questionnaire from 2014 and one from from 2015. We did not see any evidence of more recent meetings or surveys. The home's service user guide stated 'Once a year you will be given a questionnaire asking you to record your satisfaction or otherwise with the care you are receiving.'

Some audits were in place but they varied in quality, for example the accident and incident audit provided detailed information, but the environment audit was unclear about how issues would be addressed. The most recent infection control audit and action plan had been carried out on 30 April 2016. In the 'safety checks' file we found a medication audit dated 20 January 2016 but there was no name to indicate who had carried it out and we saw no follow up actions from this audit.

A 'manager's action plan' recorded various issues, for example on 20 January 2016 a 'failure of some call bells' had been identified. We did not see evidence that this had been addressed and during the inspection we found that some call bells were not working. The service user guide stated 'Currently we are using the Registered Nursing Home Association's Blue Cross Mark of Excellence as our preferred Quality Assurance Standard', but we did not see any evidence of how this was implemented.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good governance

A small office contained files with personal information about people who lived at the home. The files were not in locked cupboards and the office door did not have a lock. This meant that the confidentiality of the information was not ensured.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People living at the home did not have their legal rights protected with regard to the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided and to seek and act on feedback from relevant persons.