Care Quality Commission

Pressbeau Limited

Hill Top Lodge

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 well-led?	Requires Improvement

Overall summary

The provider is registered to accommodate and deliver nursing and personal care to a maximum of 85 people who may have dementia or an associated need. At the time of our inspection 67 people were living there.

This focussed inspection was unannounced and took place on 10 March 2015.

Care and support was provided from three units within the premises these were called Willow (ground floor) Lavender (middle floor) and Bluebell (top floor).

Our previous inspections found that there were breaches and/or repeated breaches of the law from 2012 to present. The issues relating to the breaches continued to place people at risk of accidents and incidents due to insufficient staffing levels, insufficient action to ensure people's welfare and safety, needs not being consistently met and unsafe medicine practices. In the summer of 2014 the local authority told the provider that they must restrict new admissions to the home until improvements had been made.

Following our last inspection of 7 August 2014 the provider sent us an action plan to tell us what they would do to meet the legal requirements concerning the breaches. We undertook this focused inspection to check that they had followed their action plan. We found that improvements had been made in some areas but in others breaches continued.

A manager was not registered with us as is required by law. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Summary of findings

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.

We found that medicines were not being managed safely or to ensure that people received their medicine as it had been prescribed by their doctor.

We found that staffing levels were not always adequate to meet people's needs and prevent the risk of them sustaining injury.

Staff did not support people with their hydration needs. We found that staff did not offer people a drink when they got up in the morning or sufficient fluids throughout the day to meet their care and health needs.

We found that the monitoring processes the provider had in place were not effective to make improvements to prevent breaches and repeated breaches of the law. Monitoring systems had not been effective to prevent people being placed at risk of injury or their needs not being met.

The provider had taken some action to comply with the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This better ensured that people received care in line with their best interests and were not unlawfully restricted.

The provider had taken action to ensure that equipment was safer to use and had reduced the risk of scalding from excessive hot water temperatures.

This report only covers our findings in relation to our following up of the previous breaches. You can read the report from our last comprehensive inspection by selecting the all reports link for Hill Top Lodge on our website at www.cqc.org.uk.

You can see what action we told the provider to take at the back of this report.

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?
The service was not safe.

Systems were not robust or safe enough to ensure that people were given their medicines as they had been prescribed.

Staffing levels did not consistently ensure peoples safety and welfare.

Requires Improvement

Is the service effective?
The service was not effective.

Appropriate steps had not been taken to ensure people's needs were met and that they were protected from untoward incidents and injury.

People were not encouraged or supported to drink in sufficient quantities to prevent them suffering from ill health.

Staff were aware of and better understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff ensured that people were not unlawfully restricted and received care in line with their best interests.

Requires Improvement

Is the service well-led?
The service was not well-led.

Systems in place did not prevent repeated breaches of law which placed people at risk of not having their care, welfare and safety needs consistently met.

A registered manager was not in post as is required by law.

Not all conditions of registration were consistently met. We were not officially notified about some incidences that had occurred.

We observed situations that showed that staff were not working as they should which did not demonstrate a service that was well led.

Requires Improvement

Hill Top Lodge

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 which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook an unannounced focussed inspection on 10 March 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 7 August 2014 inspection had been made. Our inspection team included an inspector, a pharmacist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. We started our inspection before 8am. This gave us the opportunity to meet and speak with some night staff.

Two months prior to our inspection we attended a meeting that the local authority arranged with the provider and a range of health and social care professionals who were involved with the service. This gave us an overview of where the service was in terms of improvements and changes that had been made. We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as notifications. We looked at the notifications the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

On the day of our inspection we spoke with the acting manager, the regional manager, 11 staff (which included some night staff), seven people who lived there, six relatives and two health care professionals. Not all people were able to fully communicate verbally with us so we spent time in communal areas and observed their interactions with staff and body language to determine their experience of living at the home.

We looked at four people's care records, 10 people's medicine records, accident records, records the provider had been asked to submit weekly by the local authority and the systems the provider had in place to monitor the quality and safety of the service provided. We also looked at the training matrix and hot water temperature recordings.

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Is the service safe?

Our findings

Our previous inspection found a breach of the law as the provider had not taken appropriate steps to ensure that the management of medicines was effective or safe. The breach was highlighted in our August 2014 inspection report. The provider sent us an action plan following that inspection and gave us assurance that a 'medicine lead' had been appointed who would oversee the medicine systems to make improvements.

During this inspection our pharmacist looked in detail at 10 medicine administration records and found that people's medical conditions were not always being treated appropriately by the use of their medicines. We found some of the medicines administration records were not able to demonstrate that people were getting their medicines at the frequency that their doctor had prescribed them. We found an administration error had taken place with a blood thinning medicine. We found another person had not received the correct dose of their inhaled medicines.

We spoke with a relative about the administration of medicines for their family member [a person who lived there] and we were told that the medicines were given on time when the permanent members of staff were on duty but when the agency/bank staff were on duty they were usually administered late, which distressed their family member.

We looked at records for people who were having medicinal skin patches applied to their bodies. We found that the provider was not making a record of where the patches were being applied and therefore the provider was not able to demonstrate that the skin patches were being applied safely. We found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary safeguards were in place to ensure that these medicines were administered safely.

We found that the information available to the staff for the administration of when required medicines was not robust enough to ensure that the medicines were given in a timely and consistent way by the nurses and care staff. Medicines were not always being stored securely for the protection of people who lived there. We found that topical medicines were being kept in people's rooms and therefore people could inappropriately use these products.

We found the management of medicines was audited by the service however, the frequency of the audit process was not robust enough to ensure that discrepancies with the medicines were identified and dealt with in an effective manner.

We found that the registered person had not protected people against the risk of the unsafe use and management of medicines. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspections of April 2013, October 2013 and August 2014 found breaches with the law as the provider had not taken appropriate steps to ensure at all times there was sufficient staff to meet people's safety and welfare needs.

During this recent inspection people who were able to communicate their views and relatives had mixed feelings about staffing levels. A person said, "Sometimes there are not enough staff and we have to wait a long time". Another person said, "Just about". A relative told us, "No there are not enough staff". Another relative said, "Yes I do [think there were enough staff] from what I have seen". Staff we spoke with during our inspection all confirmed that staffing levels were generally adequate except for nights on Willow unit.

Prior to our inspection we received information which highlighted that there were not enough night staff provided on Willow unit to meet people's needs and to keep them safe. Staff we spoke with told us that on Willow unit at night there were only two staff. We looked at two people's care records who were accommodated on Willow unit. One person's records detailed that their behaviour that challenged had placed another person at risk of injury. The second person's care records highlighted that they needed to be monitored. Whilst the two staff were elsewhere in the premises the person had fallen and sustained an injury. The provider had a staffing tool to determine staffing levels but it had not taken into account those people's needs.

At lunchtime on Lavender unit we observed a person in the corridor who was very distressed. They had removed their

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Is the service safe?

continence pad and did not know what to do. They were very agitated and visibly upset and shaking. We had to go and find a staff member to deal with the situation as no staff were available in the area where the incident happened.

At lunchtime on both Willow and Lavender unit we observed that a number of people were sat at the dining table with other people or nearby to other people who already had their meals. Those people had to wait at least 10 minutes to be assisted as there no staff free to undertake the task. One person was upset. They kept saying, "Where is mine"? This meant that people did not receive their meals when they wanted them.

We found that the registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of staff to meet people's needs and to keep them safe. This was a continued breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we observed staff using wheelchairs to move people without using footrests this could have placed people at risk of injury. During this recent inspection we made observations on all three units and saw that wheelchairs had the required footrests. The acting manager said, "We ordered new footrests and all wheelchairs have them fitted". This meant that the risks to people from wheelchair usage had been reduced.

At our previous inspection we saw that a number of doors were propped open by stools or bedside cabinets. During this inspection we made observations on all three units and did not see any doors propped open. The regional manager said, "We have had some new door closures so the staff do not need to prop any door open". At our last inspection we observed that the water from one shower was too hot. During this inspection as the hot water temperature recordings were not available when we asked for them, the nominated person for the service provided them to us by email a few days later. We looked at the records and did not see any hot water temperatures were higher than they should have been. This meant that the provider had taken steps to decrease risks to people by addressing the issues we raised following our last inspection concerning the safety of equipment.

During our previous inspection we observed two people who were being cared for in their bedroom had no way to attract staff attention or summon help if they needed it. Risk assessments had not been undertaken regarding those people not being able to summon help. During our most recent inspection we made observations of people who remained in their bedrooms. We did not identify anyone who was calling for help, or required help for which they could not summon. One person said, "I press the button and the staff come to me". Staff told us that they explain to people and show them how to use the call system to promote their understanding of how to use the system.

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Is the service effective?

Our findings

Over the last three years we have found breaches with the law as the provider had not taken appropriate steps to ensure that each person was protected against the risks of receiving care and support that is inappropriate or unsafe. Breaches were highlighted in our reports for inspections carried out in January 2012, April 2013, August 2014 and the most recent 10 March 2015. This did not give assurance that the service was effective.

Although some issues concerning the August 2014 breach had been addressed we found issues that demonstrated that people were still not being protected against all risks of receiving care and support.

People we spoke with gave us their views about the effectiveness of the service which included, "No-one to look after you proper, but it's alright". "Just about" [They looked after them], and, "It is good".

Records relating to falls highlighted that since the start of 2015 on at least 13 occasions people had been, "Found on floor", or an "Unwitnessed fall". Care records highlighted and staff confirmed that a person had been assessed as being at high risk of falls. In the early morning before our inspection they had an unwitnessed fall in the lounge during which they sustained an injury and had to go to hospital. Records highlighted that this person often stayed in the lounge at night time rather than going to bed. Records to prevent the person falling stated, "Staff need to monitor and be aware of my whereabouts". The records confirmed that at time of their fall they were not being monitored as both staff were attending to other people in another area. This showed that the provider had not taken appropriate steps to ensure that this person was protected from the risk of injury from falls.

On Lavender unit we heard a person shouting a number of times indicating that they were feeling discomfort. They shouted, "I've been in this chair all morning and bottom isn't half sore". At least four staff were in the room at the time when the person shouted loudly. The person's records highlighted that they should be moved every three to four hours. Staff told us that the person had been moved when they got up that morning which was less than three hours previously. It was not until we asked staff what they needed to do to relieve the person's discomfort that they fetched the hoist to change their position. This showed that the care to the person was not effective in preventing their discomfort.

During our previous inspection we identified that people were not being offered drinks. During our recent inspection we found that the situation had not consistently improved. People and their relatives had mixed views as to whether sufficient fluids were offered. A person said, "Yes I have plenty of drinks".

One person said, "I have been up for a long time and have not had a drink". We looked at the fluid record for the person and there was no entry since the evening before. Day staff told us that it would be the night staff that gave the drinks so they did not know if people had or had not been offered or given a drink. Later we heard another person asking for a drink. We saw that staff members were sat close to the person doing paper work but did not respond. At lunch time we observed that staff gave a person a drink. They consumed that quickly. They were not asked if they wanted another drink. We observed that the person gently slid the table cloth towards them which gave them access to the drink of the person sitting opposite them which they then consumed. Staff we asked did not know how much fluid each person should consume each day to prevent ill health. This highlighted that people's fluid intake needs were not being met.

We found that the registered person had not protected people against the risk of receiving care or treatment that was inappropriate or unsafe. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. CQC is required by law to monitor the operation on the DoLS and to report on what we find.

During our previous inspection we identified that the provider was not complying with DoLS. We saw that tables

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Is the service effective?

were placed in front of people restricting their movement and one person told us that they were not allowed to go outside for a walk. During our recent inspection no person told us that they wanted to go out but could not. We did not see any tables in front of people that could restrict their freedom of movement. We saw people freely walking around the premises. One person said, "I can move around whenever I want to". We heard one person saying that they wanted to go home. We spoke with staff and looked at the person's records. Both confirmed that the provider had taken action regarding this request and that a DoLS referral had been approved by the local authority. This meant that the provider had taken steps to enhance people's rights and ensure that they were not unlawfully restricted.

Requires Improvement

Is the service well-led?

Our findings

Five of our inspections (including this recent one) had identified breaches and/or continued breaches of the law across a number of regulations from January 2012 to present. The issues related to breaches that placed people at risk of accidents and incidents due to insufficient staffing levels, insufficient action to ensure people's welfare and safety, needs not being consistently met and unsafe medicine practices. We found that the action taken by the provider had not prevented breaches and continued breaches of the law which did not confirm that an effective operation of systems was in place to prevent risks to people and meet their needs.

People we spoke with had mixed views about the service provided. A person said, "It is not much good here". Another said, "It is good here".

Our previous inspection of August 2014 highlighted that there was no registered manager. Since that inspection, the acting (unregistered) manager who was in post at that time left employment and another new manager had been appointed. It had been 11 months since the provider has had a manager who was registered with us which means they are not complying with requirements. We asked the acting manager if they had applied for registration. They told us they knew they had to but had not.

Following our previous inspection the provider told us of the systems they had introduced to make improvements to medicines management. During this inspection we found that the systems introduced did not ensure that people were getting their medicines as their doctor had prescribed them. This meant that people were being placed at risk of poor health. We saw that the management of medicines was audited however, the frequency of the audit process was not robust enough to ensure that discrepancies with the medicines were identified and dealt with in an effective manner.

The acting manager told us about the systems they had in place, which included a staffing levels tool to determine what staffing levels were required. However, our observations during our inspection highlighted that the tool used had not ensured that sufficient staff were provided. The outcome of this was that some people were distressed and were at risk of injury.

Records relating to falls highlighted that since January 2015 on at least 13 occasions people had been, "Found on floor", or recorded as an, "Unwitnessed fall". Although the provider had a system in place to record the falls and had taken some action including referring people for assessments this had not been fully effective as people's fall prevention plans had not been followed. This showed that systems to ensure that people were protected from the risk of injury from falls were not effective.

The acting manager told us that monitoring systems were in place regarding staff that included observation and supervision. We saw staff on two of the three units sitting together writing notes whilst people were making requests and one person was distressed and shouting for attention. We raised this with the acting manager who told us that staff had been told previously not to sit writing notes at the same time and that should not be happening. This highlighted those systems in place to ensure that staff worked as they were expected to were not robust and as a result people's needs were not being addressed or met.

Not all conditions of registration were met as the provider had not kept us informed of every event that they should have informed us of. On the day of our inspection two people had falls and were sent to hospital. However, we were not officially notified about these or informed afterwards of any injuries sustained.

We found that the operation of systems the registered person had in place was not effective to prevent risks to people and meet their needs. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that there were processes in place for them to give their views on the service provided. They told us that meetings were held where they could give their views. One relative said, "They [the management] are very good. If you want to talk to someone we can always talk to them". Another relative said, "If I have a problem I always ask and they put me right".

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The above regulation corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider did not have an effective system in place to regularly assess and monitor the quality of service that people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The above regulation corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The above regulation corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: People who use services were not protected against the risks associated with not having their needs met because the registered person had not taken appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons on duty to meet people's needs.
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The above regulation corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: People who use services were not protected because the delivery of care did not ensure their welfare and safety.