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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

Hilbre House is a residential care home providing personal care and accommodation for up to 22 people, in one adapted building. At the time of the inspection 10 people were using the service. The home is a detached building, in a residential area with a coastal location and views over Liverpool Bay.

People's experience of using this service and what we found
There was no staff team at Hilbre House. Nearly all the staff who had been working at the home had recently left their employment. The provider put in place an interim emergency rota for care staff. Staffing at the home was stretched and unsustainable and people were mostly receiving care from staff that they were not familiar with.

The provider recognised that the current staffing arrangements lacked stability and were taking steps to improve this.

Medication was not always stored and administered safely. Medication recording errors had not been investigated within a reasonable timeframe. The provider arranged for a refresh of medication training and practices at the home within a short period of time.

Aspects of the home's environment were not safe and some practices at the home did not ensure people were kept safe from the spread of infection. There was no staff member who was taking the lead with infection prevention and control (IPC)

The management of the home was unstable. Prior to our inspection the provider had made the registered manager of the service redundant. This meant that the service did not have a registered manager in place.

The provider had failed to effectively monitor the care and accommodation being provided to people to ensure it was safe and of high quality; and had failed to take appropriate action when things went wrong.

People's care plans showed that they had been consulted with, in regard to choices about their care. Family members told us that communication with the home was fine.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 18 December 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing arrangements at the home. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

The provider took prompt action to mitigate the risks in relation to the homes environment and quickly sought appropriate medication training.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hilbre House 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 COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to failing to ensure safety monitoring was effective at the home, staffing and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hilbre House

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Hilbre House 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two people's relatives about their experience of the care provided. We spoke with the provider, five members of staff and a volunteer. We reviewed a range of records; this included looking at ten people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, such as audits.

After the inspection
We continued to seek clarification from the provider and to ask further questions to validate the evidence found. We sought evidence in relation to safe recruitment and policies in place.

We asked the provider to forward us contact details for people's family members. The provider told us that they communicated with people's family members and following this only one person's family member chose to share their details with the CQC. We spoke with this family member by phone.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- There were some concerns about safety of the home's environment. For example, the door in one room giving access to a first-floor patio area was not secure and had no closure mechanism. The use of window restrictors on transom windows was inconsistent, one person's room had no door handle on the inside or outside and an empty but accessible room had a broken windowpane.
- Food storage temperatures, safe cooking temperatures and daily checks of the kitchen had stopped three days earlier when the chef had left their employment.

The provider had failed to ensure safety monitoring was effective at the home. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The concerns about the home's environment were quickly addressed by the provider.

Staffing and recruitment

- There was no staff team at Hilbre House. Nearly all the staff who had been working at the home had recently left their employment; including senior staff, care staff and ancillary staff. Only one member of staff from the team who had been supporting people at Hilbre House remained.
- The provider put in place an interim emergency rota for care staff. Care was being provided each day by a director of Hilbre Care Ltd, a series of bank staff and staff from the providers other home. The rota did not include details of ancillary roles, for example who was cleaning and cooking.
- On the day we visited the director was also involved in meal preparation; as a cook did not arrive until after 11:40. The cook told us they had been asked to come in only that morning. A cleaner arrived mid-morning, it was their second time at the home and the first time in a cleaning role. In the afternoon administration staff were answering people's call bells and checking on people. The arrangements in place were precarious and unsustainable.
- Staffing at the home was stretched, there was a focus on completing tasks and responding to people's immediate needs. People were mostly receiving care from staff that they were not familiar with.

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

- The provider recognised that the current staffing arrangements lacked stability and was an emergency arrangement. They told us that they would not be admitting any new people to the home until a stable and consistent staff team was in place. They advised that recruitment was underway. Following our inspection,

the provider forwarded us rotas for the upcoming weeks that showed staff allocated to supporting ancillary roles.
● Robust recruitment processes were not always followed. One person who was volunteering at the home had not had appropriate checks completed before spending time with people unsupervised.

Using medicines safely
● Medication was not always stored and administered safely. The medication room door was wedged open, the medication fridge was unlocked, and some medication had been left on top of the medication fridge.
● The way medication was being administered was not safe. The person administering and signing for the medication, then passed it onto another staff member to give to a person in their room. Some people's medication was waiting on their breakfast trays to be given to them by staff with their breakfast. These methods of administering medication were against guidance and increased the chances of errors occurring.
● Medication recording errors had not been investigated within a reasonable timeframe.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The storage and administration of medication was not safe.

We highlighted this to the provider on the day of our inspection. They arranged for a refresh of medication training and practices at the home within a short period of time.

Preventing and controlling infection
● There was no staff member who was taking the lead with infection prevention and control (IPC). There was no person on the staff rota with the allocated role of cleaning; and there were no recent cleaning schedules in place to record what cleaning had taken place at the home.
● Staff completing cleaning were not using suitable cleaning products in line with IPC guidance, even though these were available. It was the first time this staff member had cleaned at the home.
● Staff were not consistently disposing of PPE in a timely and safe manner.
● Staff took a lunch break in the homes dining room/conservatory area and removed their face masks for eating whilst in the presence of people living at the home. There were no arrangements in place for staff to have a break safely, while reducing the risk of the spread of any infection.
● There was no evidence that one-person volunteering at the home had completed any COVID-19 rapid tests before being in close proximity to people.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We gave feedback to the provider about these areas of concern and have signposted the provider to resources to develop their approach.

● Staff partook in regular COVID-19 PCR (laboratory-based) and LFT (rapid result) testing, to help prevent any spread of COVID-19.

Systems and processes to safeguard people from the risk of abuse
● This service had a history of making appropriate safeguarding referrals and of working alongside the local authority to ensure that people were not at risk of abuse or neglect.

Learning lessons when things go wrong
● Appropriate action was not always taken when things went wrong. An incident had recently happened at

the home which had posed risk to a person. The provider had not sufficiently investigated the incident and had shared information with the local authority that was incorrect.

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

We raised a safeguarding alert with the local authority so that the incident could be investigated.

Requires Improvement

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 remained the same.

Previously this key question was rated as requires improvement because there had not been a registered manager in place between January 2018 and our inspection in October 2019. Having a registered manager in place is a condition of the registration for Hilbre House; one had not been in place for a period of 21 months. There were no breaches of regulation during our previous inspection.

At this inspection there was again no registered manager in place, and we identified breaches of regulation. The service management and leadership has been inconsistent.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The management of the home was unstable. Prior to our inspection the provider had made the registered manager of the service redundant, meaning the service did not have a registered manager in place. Having a registered manager is a condition of the registration for Hilbre House; this meant that the provider had themselves placed the home in breach of the conditions of its registration.

We have highlighted to the provider that Hilbre House requires a registered manager.

- There had been a serious breakdown in the relationship between the provider and previous registered manager which had negatively impacted on the home. Both the provider and previous registered manager attributed the relationship breakdown and decline in service at the home to each other.
- The provider had appointed a person to ensure compliance with the regulations and to complete audits of their homes including Hilbre House. This is not sufficient, to comply with the conditions of registration there still needs to be a registered manager in place approved by the CQC who has responsibility for, and oversight of, the quality of these processes.
- The provider told us that maintenance of the home had not taken place in the last six months because the previous registered manager had stopped this from happening. Records regarding the maintenance of the home's environment stated that maintenance problems had been reported to the provider over previous months and the registered manager had been recruiting a maintenance person for the home; the provider disagreed with this.
- The provider had failed to effectively monitor the care and accommodation being provided to people to ensure it was safe and of high quality. This included monitoring the safety of the environment, safe food preparation, staffing of the service, safe medication administration, taking all steps to prevent the spread of infection and taking steps to learn lessons when things go wrong.

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

- The provider had a track record of being inconsistent when making sure the duty of candour obligations were being met across their services.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

- People's care plans showed that they had been consulted with, in regard to choices about their care.
- Family members told us that communication with the home was fine.
- The vast majority of the staff team had recently decided to leave the service.

Continuous learning and improving care

- The provider had not ensured the quality of the service provided for people had been maintained.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure safety monitoring was effective at the home. The storage and administration of medication was not safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to effectively monitor the care and accommodation being provided to people to ensure it was safe and of high quality. Appropriate action was not always taken when things went wrong.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed at the service.