Hilbre Care Limited

Hilbre House

Inspection report

The Chalet
St Margarets Road
Hoylake
Wirral
CH47 1HX

Tel: 01516326781
Website: www.hilbrecaregroup.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 15 December 2017 and was unannounced.

Hilbre House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hilbre House is registered to provide accommodation and personal care for up to 22 people. At the time of the inspection there were 21 people living in the home.

A registered manager was in post, but was not available during the inspection as they were on a period of leave. 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 this inspection we found that the provider was in breach of regulations and was not meeting legal requirements. The breaches of regulation were in relation to risk management, medicines management, staff support systems and the leadership and running of the service.

People we spoke with told us they felt safe living in Hilbre House. We found however, that adequate systems were not in place to ensure the safety of all people living in the home, such as call bells in all rooms. We also found that the environment was not always safe for all people as not all windows were restricted as required and chemicals were not stored safely. This could pose risks to vulnerable people.

Emergency evacuation procedures did not provide information as to how all people would be supported to leave the home in the event of an emergency and not all people had a personal evacuation plan in place.

Risk was not always assessed accurately and people did not always receive safe care and treatment. The service accepted people into the homes with assessed needs that they were not registered to provide. The service did not adhere to agreed changes regarding pre admission procedures to help ensure people's needs could be effectively met from the day they were admitted to the home.

Medicines were not always managed safely within the home as they were not stored securely and not all medicines were administered as prescribed.

The provider did not always demonstrate a caring approach as identified risks were not always addressed to ensure people would receive safe care and treatment.

Audits completed within the service did not highlight all of the concerns raised during the inspection. When actions were identified, we found that not all had been addressed in a timely way, including those raised

from audits completed by external professionals.

There was no evidence that the provider maintained full oversight of the service and in the absence of the registered manager, the leadership of the service was unclear.

Not all statutory notifications had been submitted to the Commission as required by law.

There were a range of policies and procedures in place to help guide staff in their practice, however not all were up to date and not all were followed in practice, such as the pre admission procedure.

There was a safeguarding policy in place, however not all staff we spoke with were knowledgeable about safeguarding processes and how to raise concerns. A whistleblowing policy was in place which encouraged staff to raise any concerns without fear of repercussions.

Staff were supported in their role through induction and regular supervisions, however they did not receive an annual appraisal and not all staff had completed training necessary to enable them to meet people's needs effectively.

We looked at how staff were recruited to the home and saw that most safe recruitment practices were adhered to. However, we found that there was not always sufficient staff on duty to meet people's needs in a timely way, specifically overnight. We also found that staff rotas did not accurately reflect the staff on duty.

The home appeared clean and well maintained and personal protective equipment was available for staff to help prevent the spread of infection.

Applications to deprive people had been made appropriately. We found that people's consent was sought and recorded in line with the principles of the Mental Capacity Act 2005.

People's nutritional needs were assessed regularly and met by the service. When risks were identified, appropriate referrals were made for specialist advice. People told us they had enough to eat and drink and enjoyed the meals provided to them.

People told us that staff were kind and caring and that they were treated with respect by staff and relatives agreed. We observed people's dignity being promoted during the inspection.

Care files we viewed showed that people were encouraged to be as independent as possible and the provider had policies in place which reflected that one of the aims of the service was to encourage people to be as independent as possible. Equipment was provided to people when needed, in order to maximise their independence.

Information regarding the service was available to people.

Relatives were able to visit their family members at any time and we saw that they were always made welcome. For people that did not have friends or family to represent them, information regarding advocacy services was available within the home.

Care plans were detailed and centred on the needs and preferences of the individual person. They had been reviewed regularly but were not always updated to reflect changes to the recommended care.

A system was in place to manage complaints and those we viewed had been investigated and responded to in line with the provider's policy.

In order to gather feedback regarding the service, staff meetings took place and quality assurance questionnaires were distributed for completion. This could be further developed to include meetings for people living in the home or their relatives. The people we spoke to who lived in Hilbre House, told us they enjoyed living there, that it was friendly and they felt able to raise any issues with the management of the home.

Ratings from the last inspection were displayed within the home and on the provider's website as required.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

Systems were not in place to ensure people's safety and the environment was not always safely maintained.

Risk was not always assessed accurately and people did not always receive safe care and treatment.

Medicines were not always managed safely within the home.

Not all staff were knowledgeable about safeguarding processes and how to raise concerns.

Staff were recruited safely, however there were not always sufficient staff on duty to meet people's needs.

The home appeared clean and well maintained and personal protective equipment was available for staff to help prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had completed training necessary to enable them to meet people's needs effectively.

Staff received regular supervisions, however annual appraisals were not evident.

Applications to deprive people of their liberty had been made appropriately.

People's consent was sought and recorded appropriately.

People's needs were assessed holistically once they moved into the home.

Is the service caring?

Requires Improvement

The service was not always caring.

A caring approach was not always demonstrated by the provider.

Information regarding the service and what could be provided was not always clearly communicated.

People told us that staff were kind and caring and that they were treated with respect. We observed people's dignity being promoted during the inspection.

Care plans showed that people were encouraged to be as independent as possible and equipment was provided to enable this when needed.

People told us they were involved with their plans of care and were encouraged to be as independent as possible. Care files we viewed reflected this involvement.

Relatives were able to visit their family members at any time and were always made welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Preadmission assessments did not identify people's needs so staff could not be responsive to them from the day of admission.

Care plans had been reviewed regularly but were not always updated to incorporate changes in recommended care.

A system was in place to manage complaints.

People were happy with the activities available to them.

Staff worked with community health professionals to help ensure people received appropriate care at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place to monitor the quality and safety of the service were not effective. There was no evidence that the provider maintained oversight of the service.

Day to day leadership and management of the service was unclear in the absence of the registered manager.

The service did not adhere to agreed changes in procedures.

Not all statutory notifications had been submitted to the Commission as required by law.

There were a range of policies and procedures in place to help guide staff in their practice, however not all were up to date.

Ratings from the last inspection were displayed within the home and on the provider's website as required.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We last inspected this service in January 2017 and it was rated as good overall. Since that inspection we had been made aware of concerns from Wirral local authority in relation to the care and treatment provided at the service. We therefore undertook another comprehensive inspection in order to review potential risks within the service.

This inspection took place on 12 and 15 December 2017 and was unannounced.

The inspection team included three adult social care inspectors.

Prior to the inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the Local Authority and the local Clinical Commissioning Group to get their opinions of the service.

We used this information to plan how the inspection should be conducted.

During the inspection we spoke with three people living in the home, five relatives, four members of the management team, the chef and three members of care staff. Following the inspection we also spoke with a social worker.

We looked at the care files of five people receiving support from the service, five staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various times during the inspection.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living in Hilbre House and their relatives agreed. Comments included, "She's safe here", "I feel very safe" and "I'm very, very happy, I have peace of mind."

We found however, that adequate systems were not in place to ensure the safety of all people living in the home. For instance, we found that call bells were not available in all bedrooms in order to enable people to alert staff when they required assistance. We were told that not everybody was able to use a call bell due to memory difficulties, however we saw that two people who we were told could use a call bell, did not have one in their rooms. The acting manager told us the provider was in the process of arranging a new call bell system. On the second day of the inspection we were told that additional call bells had been ordered for use until the new system had been installed.

We saw that systems were in place to monitor the environment and equipment. For example, external contracts were in place to make regular checks on the gas, electricity, lifting equipment, call bell system and emergency lights. Records also showed that regular internal checks were completed to check water temperatures, legionella prevention, fire alarms and portable electrical equipment.

However, we found that the environment was not always safely maintained. For example, window restrictors were not fitted to all windows as required, in order to prevent falls from height. We also saw that chemicals were not always stored securely, as a cleaning trolley with cleaning chemicals was stored in an unlocked cupboard. This meant that vulnerable people living in the home had access to chemicals that could cause them harm. We also saw that the linen cupboard which contained a sign stating it should be locked shut. The door was unlocked and very full of linen so that the door could not be easily opened or closed without obstruction. This posed a fire risk as the excess linen could act as fuel in the event of a fire.

We looked at the emergency evacuation procedures in place to help ensure people's safety and found that they did not provide information as to how all people would be supported to leave the home. For instance, one part of the policy stated, "Some means of extracting non-ambulant residents needs to be thought about and put in place as a matter of urgency. A device similar to a bed sled would be the ideal." Personal emergency evacuation plans (PEEPs) informed what support people needed should they need to evacuate the home. However, we saw that PEEPs were not in place for all people and for people who were unable to manage the stairs, the PEEPs reflected use of a stretcher.

A stretcher was stored under the stairs on the ground floor of the home. A staff member we spoke with told us they had received training to use the stretcher; however this did not include any simulation and had not used the stretcher on the stairs, or with a person on it. Staff we spoke with were not sure whether the stretcher would fit around the turns in the staircase. This meant that safe evacuation procedures were not in place for all people. We shared our concerns with Merseyside Fire Service on the first day of the inspection. The fire service had completed an inspection of the home in September 2017 and recommended that the provider expanded the evacuation procedure to reflect how people would be assisted to evacuate to the ground floor and to ensure any equipment necessary to do this was in place. We found that these

recommendations had not been actioned.

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

Care plans we viewed showed that risk assessments were completed regarding people's care needs. These included areas such as risk of falls, skin integrity, mobility and malnutrition. We also saw that when people were assessed as at risk, measures were put in place to reduce the risks. For example, one person's care file showed they were at risk of malnutrition due to a poor appetite. We saw that the dietician had been contacted for advice and the person's intake had been monitored to help ensure they were eating sufficient amounts of food.

However, we found that not all risks were fully assessed or identified and people did not always receive safe care and treatment. For example, we had received concerns that people had been admitted to the home that had been assessed as requiring nursing care. This service is not registered to provide this level of care. Following the first admission of a person with assessed nursing needs, a safeguarding investigation was undertaken and substantiated. Assessment and admission practices within the home were changed to help ensure this did not happen again. However, during this inspection we were made aware of another person who had been admitted to the home with nursing needs. We found that the new assessment procedures had not been adhered to an effective assessment had not been undertaken prior to the person moving into the home. The person's needs could not be safely met on the day they were admitted to the home, as required equipment was not available. This meant that there was a risk people would receive unsafe care and treatment and the provider did not demonstrate that lessons had been learnt from previous concerns.

Following the inspection, CQC used its urgent powers to keep people safe.

The provider has 28 days to appeal against this action to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. Once this period has passed, the action will be reported upon.

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

We looked at how medicines were managed within the home. A medicine policy was in place to guide staff in their practice and records showed that staff who administered medicines had received training and had their competency assessed to ensure they did this safely. We found however, that medicines were not always managed safely. For example, medicines were stored in a locked trolley; however there was no lock on the clinic room door where the medicines were stored. We also saw that the medicine fridge in the room was not locked and medicines were stored within it. This meant that there was a risk vulnerable people could access medicines not prescribed for them. On the second day we were told a lock had been ordered for the clinic room door and saw that a new lockable fridge was in place.

The temperature of the clinic room and fridge were monitored and recorded daily as required. However, some medicines were stored in another room and the temperature of this room was not monitored. This meant that there was a risk that medicines may not be stored at the correct temperature. If medicines are not stored at the recommended temperature, it can affect the way they work.

We looked at medicine administration records (MARs) and found that although people's allergies were recorded on some charts, they were not recorded on all people's. This meant that there was a risk people

could be administered a medicine they were allergic to.

We found that medicines were not always administered as prescribed. For example, one person's MAR chart reflected that they had been prescribed a medicine for five days. They had however, received it for seven days at the time of the inspection. When we spoke with staff about this, they told us they thought it should be administered until the stock had ran out. We asked the staff member to contact the person's GP regarding this.

We also saw that not all prescribed medicines were evidenced as administered. For instance, one MAR chart showed that the person had been prescribed a powder to thicken their drinks due to swallowing difficulties. Staff told us that the person always received this; however there were no records of this.

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

We looked at how the home was staffed. We viewed the staff rotas and saw that they were not always accurate. For instance, the rota for the week of the inspection showed that the registered manager was on duty, however they were on leave. It also did not include two of the acting managers who were on duty. This meant that the rotas did not accurately reflect the staff on duty. We asked whether any assessment tool was used to establish the number of staff required to be on duty at any one time based on people's needs, but were told there was none.

Although no concerns were raised with us regarding staffing levels during the inspection, we found that there were not always enough staff on duty to meet people's needs in a timely way. For example, rota's we viewed showed that two carers were on duty overnight to support the 21 people living in the home, over three floors. Staff told us that some people required the assistance of two staff overnight which meant that there would be no staff on two of the floors at times during the night. Accident forms we viewed showed that people had on occasion fallen in their bedrooms. As not all people had access to call bells, there was a risk they could require assistance and not be able to alert staff. One of the staff members would also be responsible for administering medicines during the evening, leaving only one staff member to support people. This meant that there was insufficient staff to meet all people's needs in a timely way.

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

Although a safeguarding policy was available, not all staff we spoke with were knowledgeable about safeguarding processes and how to raise concerns. For instance, one staff member told us they would inform a manager, but if a manager was not on duty, they would not know what to do. This showed that there was no clear process in place to ensure staff knew how to raise any concerns they had and meant there was a risk safeguarding concerns may not be dealt with appropriately. We discussed this with two of the acting managers who told us staff would often contact the registered manager if they had concerns, although there was no official on call system in place to ensure staff always had access to a member of the management team.

We looked at how staff were recruited to the home. All personnel files we viewed contained references and a full employment history as required. Within one file however, there were discrepancies within the dates of employment between the reference and employment history provided by the staff member. We discussed this with the acting manager who agreed to review this with the staff member. All files contained a Disclosure and Barring Service (DBS) check. DBS checks consist of a check on people's criminal record and a

check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

The home appeared clean and was odour free. We saw the daily cleaning rotas which showed deep clean processes that were carried out within the home to help maintain cleanliness. Communal bathrooms contained liquid soap and paper hand towels in line with best practice. We also found that staff had access personal protective equipment such as gloves and aprons. We saw that these were used appropriately, such as when providing personal care or serving meals. This helped to prevent the spread of infection.

We found that records relating to people's care and treatment were detailed, legible and up to date. They reflected the care and support people required and were stored securely. Care files were accessible to all staff to ensure they had access to relevant information they required to enable them to support people safely.

The provider had a whistleblowing policy in place which encouraged staff to raise any concerns without fear of repercussions. This included contact details to relevant organisations to ensure staff were aware who they could contact should they need to.

An equal opportunities policy was also available within the home, as well as a service user rights policy. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. The acting manager's we spoke with told us there was nobody living in the home at the time of the inspection that required personalised support in relation to any of the protected characteristics.

Requires Improvement

Is the service effective?

Our findings

We looked to see how staff were supported in their roles to ensure they had the required knowledge and skills to meet people's needs. Records showed that staff completed an induction when they commenced in post. This induction was detailed and for staff without prior qualifications or experience, an induction was completed that met the requirements of the Care Certificate. The care certificate is an identified set of standards that care workers have to achieve and be assessed as competent by a senior member of staff.

Staff we spoke with told us they felt supported and that they received regular supervisions and records we viewed reflected this. There was no evidence available to show that annual appraisals had been completed to review staff members practice. We discussed this with an acting manager who told us they had not been completed. However, since the inspection, the provider has told us appraisals had been completed in June 2017.

People living in the home and their relatives, told us they thought staff were well trained. However, the training matrix provided to us showed that not all staff had completed training that would be considered mandatory in order to enable staff to support people safely. For example, out of the 13 staff recorded on the matrix, only three had completed safeguarding training. One staff member we spoke with confirmed that they had not received this training and when asked, told us they would not know how to make a safeguarding referral if they were required to do so.

The matrix also showed that only two staff had completed food hygiene training, eight had completed training in fire safety but no fire drills had been undertaken and only two staff had completed training in the prevention of pressure ulcers. This meant that staff may not have the necessary knowledge to enable them to support people safely and effectively.

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

During the inspection we looked to see if the service was working within the legal framework of the MCA. The 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 make 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 in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records showed that four applications had been made and authorised, although they had since expired. Applications to renew the authorisations had been submitted to the local authority and these were being processed. There was a system in place which recorded dates applications were made and when they were due to expire. This helped to ensure that applications to deprive people of their liberty were made in a

timely way.

Care plans we viewed showed that people's consent was sought and recorded, for decisions such as having photographs taken and for the use of bed rails when required. People we spoke with staff asked them for their consent when providing care and we heard this during the inspection. When people were unable to provide consent due to memory difficulties, we saw that mental capacity assessments had been completed and decisions made in people's best interest. When a person's relative had legal authority to consent to care and treatment on their behalf, evidence of this authority was recorded within their care file. This showed that consent was sought in line with the principles of the MCA.

We saw that care files included care plans in relation to people's mental, physical, social and health needs. This showed that once people moved into the home, their needs were assessed holistically. Records also showed that people were supported by the staff as well as other healthcare professionals. This included the GP, dietician and district nurse. People we spoke with told us they saw a doctor quickly if they were unwell and that staff would arrange this for them. We were told that a GP visited the home routinely each week to review to review people and staff told us they had a good working relationship with the practice.

Training had also been provided to some staff in preparation for a tele- triage system which was due to be implemented. This would give staff access to health advice and support 24 hours per day through a computer system.

We looked to see what systems were in place to ensure information regarding people's needs was shared appropriately when people transferred between services, such as when admitted to hospital. An acting manager told us that staff would ensure a copy of the current medication chart and personal details form was sent with people and we saw a policy in place which reflected this practice. This showed that basic information was shared, but this could be developed further to help ensure people received continuity of care that met their needs and preferences.

An acting manager told us that a number of people living in the home were living with dementia. We looked to see if the environment had been adapted to support people living with dementia, to maintain their safety and assist with orientation. We saw that some bedroom doors contained a number and a photograph of the person to help them in identifying their rooms. This could be further developed to ensure the environment supported people effectively, such as through the use of pictorial signs to guide people to areas such as the bathroom or the dining room.

We looked at how people's nutritional needs were met within the home. Care plans showed that nutritional risk assessments had been completed and people had their weight monitored regularly. When a risk was identified, referrals were made to the dietician for specialist advice. We saw that advice provided was followed. For example, one person had been prescribed supplement drinks to support their nutritional intake. Records showed that these drinks were provided and the advice from the dietician was incorporated within their nutritional care plan. We saw that when people required their intake to be monitored, this was recorded in detail.

We spoke with the chef who was aware of people's dietary needs. We saw that there was information within the kitchen and on daily records for all staff, which identified any specific needs, such as a diabetic diet or soft food.

People told us they could choose where to eat their meals and we saw this during the inspection. For people who chose to eat in their rooms or in the lounge, we saw staff take them meals on a tray. All people we

spoke with told us they had a choice regarding their meals and that they enjoyed the food provided to them. One person told us, "I don't like salmon; the chef will ring me to see what I want instead." We observed the chef phoning a person in their room to find out what they wanted for lunch that day, as they knew the person did not like either of the choices on the menu.

Relatives told us they were welcome to stay for meals and one relative told us, "The food is excellent" and another said, "The chef is excellent and the choice of food is lovely."

Requires Improvement

Is the service caring?

Our findings

People living in Hilbre House told us that staff were kind and caring and that they were treated with respect by staff. Their comments included, "They [staff] are wonderful", "They are so patient and gentle here" and "They look after me wonderfully well." Another person told us, "I would recommend [the home] to anybody." Relatives we spoke with agreed and they told us, "All the staff are marvellous", "They are very helpful" and "All the staff are like angels, very compassionate and caring."

Although people told us staff were caring, the provider failed to act on identified risks and follow procedures to ensure that people received safe care and treatment. This did not show a caring approach.

We looked to see how information regarding the home was communicated to people. There was a service user guide and statement of purpose which were on display within the home for people to access. These contained information about the service and what could be expected when a person moved into the home. Relatives we spoke with told us that they were kept informed and communication with the service was good. We found however, that people had moved into the home who had needs that could not be met by the service. This showed that systems to communicate what the service was able to provide, was not always communicated effectively to people.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. For example, we saw staff knock on people's doors and wait for a response before entering. Interactions we observed between staff and people living in the home were warm and genuine. We heard staff speaking to people in a kind way. We also observed a staff member assisting a person with their meal. This support was provided in a dignified and unrushed manner.

Care plans we viewed showed that people were encouraged to be as independent as possible. For example, one person's care file showed that they could have difficulty mobilising at times and prompted staff to encourage them to keep walking as much as possible. Another person's care plan explained that they had difficulties with communication and guided staff to use questions with a yes or no answer to enable the person to have as much choice and independence regarding their care as possible. A policy regarding service user's rights also reflected that one of the aims of the service was to promote people's independence.

We saw that aids and adaptations were in place when people needed them, to help maximise their independence. For example, one person used adapted cutlery to enable them to continue eating themselves as they struggled to use standard shaped cutlery and another person used a beaker so they did not require support to drink. Another person had a falls sensor mat in place. This alerted staff when they were out of bed so that they could offer assistance to reduce the risk of falls, whilst enabling the person to continue mobilising independently. However, we found that there were not always enough staff on duty to respond to people's needs in a timely way.

Care plans showed that people were involved with their plans of care. One person told us, "They always ask

my opinions." Relatives confirmed they were involved in care planning and one relative said, "Yes, the care plan was done in the beginning."

We saw that most care records were stored electronically. Some paper records were stored within an office which was locked when staff were not in there. The provider also had a policy in place to inform staff of the importance of confidentiality and their legal responsibilities in this area. This included disclosure of information regarding people that lived in the home as well as access to care records and personal information.

We saw friends and relatives visiting throughout the inspection and all those we spoke with told us they could visit at any time and were always made welcome. One relative told us, "There's a cup of tea under your nose as soon as you walk in." This helped people to maintain relationships that were important to them and prevent isolation.

For people that did not have friends or family to represent them, information regarding advocacy services were available within the home, although there was nobody using these services at the time of the inspection. The provider also had a policy in place with regards to accessing advocacy services on behalf of people living in the home. This helped to ensure that people had access to support and that staff were aware how to access it.

Requires Improvement

Is the service responsive?

Our findings

Care files we viewed contained care plans regarding people's needs in areas such as mobility, eating and drinking, continence, personal care, and social needs. We found that the plans were detailed and centred on the individual person, their needs and their preferences. Most contained clear information regarding people's assessed needs and how best staff could support them. We also saw that care plans were in place regarding people's medical health needs. One person's file showed that they suffered from a recurrent health issue and the care plan provided detailed guidance to help ensure staff knew what symptoms to look for and what actions to take. However, we were aware that not all people who came to live in the home had had their needs assessed accurately. This meant that staff could not be responsive to those needs on the day they moved into the home.

Care files we viewed also showed that planned care was evidenced as provided. For example, one person's skin integrity care plan showed that the person required support to reposition every four hours to prevent deterioration of their pressure areas. Records we viewed showed that this support had been provided and recorded. However, since the inspection we have been made aware of further concerns from the local authority. These concerns reflected that planned care and treatment was not always provided. For instance, advice had been provided to staff by a health professional, regarding the care a person required. This advice had not been reflected in the person's care plan. The person's condition had deteriorated and there was no evidence that the advised care had been provided. This meant that the service had not been responsive to their needs.

Care plans we viewed had been reviewed regularly and updated when changes occurred in people's care and treatment. For example, due to one person's deteriorated mobility, bed rails had been implemented to prevent falls from bed. We saw that the care plan had been updated to reflect this. This meant that staff had access to accurate and up to date information regarding people's needs.

People's preferences in relation to their care were also recorded within the care plans. This included information such as when people liked to go to bed and get up in the morning, how people preferred to be addressed, where people liked to spend time during the day and foods they enjoyed. One person's plan included advice on how to reassure them when they became anxious.
They also included 'This is me' documents which provided information regarding people's life history, where they lived, jobs they had and places they liked to go to. Hobbies, family members and significant events and celebrations in people's lives were also recorded. This helped staff get to know people and provide support based on their preferences.

People told us they were able to make choices, such as those regarding their daily routine. These included what they wanted to eat, where they wanted to eat their meals, whether to participate in activities or not and when they wanted to get up and go to bed. People told us staff encouraged choice and this was reflected within care plans.

We looked at the systems in place to manage complaints. There was a complaints policy on display within

the home which provided contact details of relevant agencies so that people could contact them if needed. There was a log maintained of all complaints received and those we viewed showed that they had been investigated and responded to in line with the provider's policy. People we spoke with told us they knew how to raise any concerns and would be happy to speak to staff if they wanted to make a complaint.

We looked at the social aspects of the home and what activities were available to people. An acting manager told us that an activity coordinator had been appointed and was due to start in post later in the week. Previously one member of the care team had been allocated to provide activities each day. People we spoke with were satisfied with the amount of activities available to them and enjoyed the variety. Relatives we spoke with agreed that there was a good range of activities available both within the home and in the local community.

We looked at systems in place to help support people at the end of their life. We found that some staff had completed training to enable them to provide effective care to people at this time. One of the acting managers told us they had previously completed the 'Six Steps' training programme. 'Six Steps' is a locally recognised training course which provides staff with the skill, tools and knowledge to support people effectively at the end of their life. However, for this certification to remain valid, regular updates and assessments are required and these had not been completed for over 12 months. They hoped to reintroduce it within the home in the near future.

We saw that staff worked with community health professionals in order to ensure that people received a dignified care at the end of their life.

Inadequate

Is the service well-led?

Our findings

During this inspection we looked to see what systems the provider and registered manager had in place to monitor the quality and safety of the service and drive forward improvements. We saw that audits were completed in a range of areas such as medicines management, health and safety, risks in the environment, falls, safeguarding, accidents, complaints and care plans. These audits had been completed by senior staff within the home.

We found however, the audits did not highlight all of the concerns raised during the inspection. For example, medicine audits had been completed monthly and included areas such as storage, administration and record keeping. These audits had not identified any actions, however we found that not all medicines were stored safely and not all were administered as prescribed. We also identified concerns regarding fire safety procedures and environmental risks such as the unsafe storage of chemicals, window restrictors and lack of call bells. None of these concerns had been highlighted through the health and safety audits completed within the service.

These audits had identified some actions required and we saw that some of these had been addressed. For instance, an audit had been completed by the contracted pharmacy in February 2017. This showed that new thermometers were required and we saw that these were in place. We found however, that not all identified actions had been completed. For example, this audit reflected that the door to the clinic room where medicines were stored, needed to be locked, but we found that there was still no lock on the door.

An inspection from the local fire service in September 2017 led to recommendations being made to improve fire safety within the service. One of these was to ensure evacuation plans included contingency plans for supporting people down the stairs in the event of an emergency. We found that this had not been completed and evacuation plans did not provide this information. This meant that there was a risk people may not be able to be evacuated safely in the event of an emergency and the service had not acted on identified risks.

We looked to see how the provider was kept informed about the service. We were told that the provider visited the home regularly; however there were no records to show what was looked at during these visits and whether the provider was made aware of significant information regarding the service.

We looked at how the home was managed. There was a registered manager in post; however they were on a period of leave at the time of the inspection. We were informed that three senior staff within the service were working together as acting managers in the registered manager's absence. Through discussions, it was clear that all three staff had their own areas of responsibility within the home; however no one person had full oversight of the service as a whole. For instance, on the first day of the inspection, two of the acting managers were on duty, but were unable to access all of the information we requested. We were told this was because the information we asked for was the responsibility of the third acting manager who was not on duty and they did not know how to access it. One of the acting managers we discussed this with told us that although they communicated any important messages between them by leaving notes in the office,

they felt this system could be improved.

This showed that the systems in place to monitor the quality and safety of the service were not effective and leadership of the service was not clear.

Following previous concerns raised regarding people being admitted to the home with needs that the service was not registered to provide, the service informed the local authority that they had amended their admission procedure. This change meant that all pre admission assessments would be completed by one of the acting managers. We found however, that this newly agreed process had not been adhered to and pre admission assessments were not always completed by the acting manager. A pre admission policy was in place which reflected that people would have their needs assessed in a range of areas, however the records we viewed showed that the assessments had not all been completed in line with this process. This led to people being admitted to the home without a full, detailed assessment of their needs and a risk that their needs could not be safely met.

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

It is a statutory requirement that the service notifies Care Quality Commission (CQC) of all relevant events and incidents that occur within the home, including any safeguarding concerns. The local authority had informed us that they had conducted three safeguarding investigations. A safeguarding audit had been completed within the home each month which also reflected these investigations. However, CQC had not received any notifications from the provider in relation to these incidents.

We discussed this with one of the acting managers who told us this was the responsibility of another acting manager to submit notifications but that they thought the local authority would have informed us. This showed that there was a lack of understanding regarding responsibilities and notifications had not been submitted in line with legal requirements. This meant that CQC were not able to accurately monitor information and risks regarding Hilbre House.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were a range of policies and procedures in place to help guide staff in their practice. We found however, that these were not all up to date. For instance, the deprivation of liberty safeguards (DoLS) policy reflected old laws that had been changed in April 2017. This meant that staff did not have access to the most up to date information regarding their responsibilities in relation to DoLS.

Some systems were in place to gather feedback regarding the service to help enable continuous improvement. These included a suggestion box, regular staff meetings and completion of quality assurance surveys. Staff meetings took place each month and we reviewed the minutes from these meetings. These showed that topics relevant to the running of the service were discussed, such as infection control, care plans, personalised risk assessments and what actions needed to be taken and activities. We found however, that there were no records of meetings to gather views from people living in the home, or their relatives. An acting manager confirmed that these had not taken place recently.

The people we spoke to who lived in Hilbre House, told us they enjoyed living there, that it was friendly and they felt able to raise any issues with the management of the home. One person told us, "You can come to the office at any time. They'll go out of their way to answer or help you."

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.