

Age Concern Liverpool & Sefton

The Hamlets

Inspection report

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Ratings

Overall rating for this service	Inadequate 
Is the service safe?	Inadequate 
Is the service effective?	Inadequate 
Is the service caring?	Requires Improvement 
Is the service responsive?	Requires Improvement 
Is the service well-led?	Inadequate 

Summary of findings

Overall summary

About the service

The Hamlets provides accommodation and nursing and/or personal care to up to 30 people with needs associated with their mental health. At the time of our inspection there were 29 people living in the home.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People's experience of using this service and what we found

Care records did not always contain the most relevant information or guidance that staff needed to follow, and people were exposed to unnecessary risk. Areas of risk were not robustly monitored, and incidents and accidents were not analysed or reviewed which meant the provider missed opportunities to prevent incidents occurring in the future

People were not always supported to receive their medications safely. People's risk assessments did not always reflect the support they required to keep them safe and people were not always supported in a person-centred way.

There was enough staff deployed to support people's needs, and staff were recruited and selected safely. The environment was clean, tidy and stocked with PPE. However, staff were not always using PPE effectively. We identified some concerns with the general maintenance of the home on day 1 of our inspection which could put people at risk.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies systems in the service did not support this practice. People had choice around what food they ate.

People told us they liked living at the home and they liked the staff who supported them. However, we observed that not all interactions between staff and people were caring or dignified.

Quality assurance systems were not effective, areas of risk were not safely managed, and regulatory requirements were not complied with. Inadequate quality assurance and governance measures meant that the provision of care people received was compromised.

Following the first day of our inspection the provider ensured the risks we escalated were mitigated and

these processes were put in place to avoid them being repeated.

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 09 July 2019)

Why we inspected

This inspection was prompted in part due to concerns received about staffing and the culture within the home. A decision was made for us to inspect and examine those risks focusing on the key questions Safe and Well-led.

We inspected and found there were concerns with other aspects of care, so we widened the scope of the inspection which included the key questions of Effective, Caring and Responsive.

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. You can see what action we have asked the provider to take at the end of this full report.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medications, risk assessments, training, Capacity and consent, person centred care and governance.

Follow up

We will request an action plan from 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this time frame, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well- led findings below.

Inadequate ●

The Hamlets

Detailed findings

Background to this 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

The inspection was carried out by an inspector, an interim inspection manager, 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.

Service and service type

The Hamlets is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. The Hamlets is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. There was a manager who was in the process of registering with CQC.

This inspection was unannounced.

What we did before the inspection

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 used the information we had about the service to formulate our 'planning tool' and plan our inspection.

During the inspection

During our inspection we spoke with 8 people who lived at the home, 2 visitors, 4 staff, the operations manager, temporary home manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and 4 agency profiles. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. The provider and registered manager sent us evidence of how they had mitigated risk, and details of the action they would take going forward.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse or harm.
- There was not a robust system for recording and responding to incidents and accidents. This meant there were missed opportunities to report incidents to the relevant safeguarding authorities, leaving people exposed to avoidable risk.
- We found a serious incident where someone had been harmed that had not been recorded or responded to appropriately. This meant we were not assured any action had been taken to prevent the incident from re-occurring.

This was a breach of Regulation 13 (1) (3) of the health and social care act 2008 regulated activities (regulations) 2008.

We shared our concerns with the provider and the local authority safeguarding team at the end of day 1 of our inspection. When we returned on day 2, we saw the provider had responded immediately by updating their documentation and putting mitigation processes in place.

- Staff were trained in safeguarding and knew what action to take in order to keep people safe.
- There was a safeguarding policy in place, this was displayed in communal areas and contained the process for reporting concerns to the local authority.
- Most people we spoke with told us they felt safe at the home, and 1 visiting relative said, "I feel that this is a safe place to leave my beloved and they will ring me if there is a need."

Assessing risk, safety monitoring and management

- Some risk assessment were not in place and some risks were not robustly assessed in order to keep people safe from harm.
- One person who was at risk of choking did not have a choking risk assessment in place. There was also inconsistent information in the person's care plan and in the kitchen with regards to the consistency of their food, which put them at increased risk of choking. The provider took action immediately and updated this information.
- Another person had a diagnosis of diabetes. However, their risk assessment with regards to managing this condition did not contain enough information with regards to their blood sugar levels and the action staff should take if they were not within normal range. Therefore, we could not be assured the person's diabetes was being managed safely.
- One person had epilepsy and did not have enough information recorded in their epilepsy risk assessment

to instruct staff how to manage this if they had a seizure. We saw from records they had recently experienced a seizure.

- One person walked in and out of people's rooms throughout the day and they could often invade people's space. We saw that risk assessments around this had not been updated following incidents.
- On day 1 of our inspection we observed risks with the fixtures and fittings in some areas of the home. For example, multiple toilet seats were missing and bedroom furniture in one person's room was broken and left unsafe.

There was no evidence people had been harmed. However, these concerns put people at risk of unsafe care and treatment. This was a breach of Regulation 12 (1) (2) (a) (b) (d) (e) of the health and social care act 2008 regulated activities (regulations) 2014.

The provider responded immediately after we highlighted our concerns and has since put the correct information in place and addressed the issues we found with risk assessments. We checked this when we returned for day 2.

Using medicines safely

- Medicines were not always managed safely.
- On day 1 of our inspection, we observed medication was left unattended on top of the medication trolley. We also observed staff dropping someone's medication on the floor, picking it back up, and handing it to them to take.
- Prescribed creams and lotions were not stored correctly and were accessible in people's rooms.
- Medication stock balances were not being counted correctly for medication to be given as and when required, often referred to as PRN, so we could not be sure stock was correct.
- Covert medication, which is medication hidden in food or drink, was not being managed safely. One person was given their medication hidden in food whole, and the medication administration record said this required crushing. There was no documented discussion or input from the pharmacy regarding what foods or drink could be used to conceal people's medication.

There was no evidence people had been harmed. However this is a breach of regulation 12 (2) (g) of the health and social care act 2008 regulated activities (regulations) 2014.

Preventing and controlling infection

- Infection prevention and control procedures were not effectively managed.
- Staff were not wearing face masks on day 1 of our inspection. This had not been risk assessed in line with guidance. When we returned for day 2, this had improved, however we still observed some staff not wearing masks correctly.
- The home was visibly clean.
- The provider was safely facilitating visiting for people.

Learning lessons when things go wrong

- We could not always be assured lessons were learned from incidents and accidents due to their being no routine analysis of incidents and accidents taking place. We discussed this with the provider who has since implemented this.

Staffing and recruitment

- Safe recruitment processes were followed. Relevant pre-employment checks were completed to ensure new applicants were suitable to work for the service.

- Staffing numbers were based upon people's level of dependency. Observations showed there were enough staff deployed to meet people's needs.
- The provider was open and transparent regarding the barriers they were facing with regards to recruitment of staff. Due to this, there was a heavy reliance on agency staff to cover most of the shifts at the home.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff had completed all training the provider had deemed mandatory for their roles.
- Agency staff had also completed mandatory training, however we did see some training for agency staff was out of date.
- Regular and agency staff had not received specific training to be able to support people with learning disabilities and those with mental health needs. Therefore, we were not assured staff would always interact with people appropriately when they were becoming distressed or unwell. One person's risk assessment with regards to helping them manage their mental health needs was to 'interact with them and look for signs and triggers'. However, staff had not had training about what the signs and triggers were.
- The provider informed us staff had undergone supervisions. However, due to the manager not being in the service they were unable to provide evidence of this.

Not ensuring staff have the correct skills, training and support is a breach of regulation 18 (2) (a) of the health and social care act 2008 regulated activities (regulations) 2014.

The provider has responded to these concerns and has since organised for staff to attend more role specific training.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- DoLS were in place for people and the manager was in the process of reviewing each person's

authorisation. However, there was inconsistent information regarding people's decision-making abilities and the choices they could make. We were not assured the service was always acting in people's best interest.

- Two people had DNACPR (do not attempt cardiopulmonary resuscitation) in place. However, there was no best interest decisions in place around this, and no supporting documentation that the decision had been made in people's best interests.
- People who were subject to covert medications did not have any record of best interest meetings being held to discuss if that approach was the best for that person.
- One person who had fallen out of bed did not have bedrails in place. We could not be sure if bed rails had been considered in their best interests to prevent the person from falling, and the rationale if they were not appropriate.

There was no evidence people had been harmed as a result of this, however these examples are a breach of regulation 11 (1) of the health and social care act 2008 regulated activities (regulations) 2008.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink food of their choice.
- People we spoke with said they enjoyed the food, and they had a lot of choice. One person said, "The food is lovely, you get bacon, egg and toast."
- Staff were offering people drinks and snacks throughout the day.

Adapting service, design, decoration to meet people's needs

- The provider was aware some parts of the home required redecoration.
- The home was kept clean and tidy however, some people's bedroom fixtures and fittings required updating and were unsafe. We observed on day 1, various missing toilet seats, and broken furniture in rooms which could put people at risk of harm. We have reported on this under the Safe section of our report.

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Staff had made referrals for some people in line with their needs, however some of the records regarding these referrals were not always clear.
- Some people had signed their own care plans when they were first admitted to the home. However, we were not sure if they been involved in any recent reviews about their care and support or their level of understanding regarding their care plan, as it was not documented this had been discussed with them.
- We could not see any evidence that advocacy had been considered for some people to represent them who did not have family or next of kin. We raised this with the provider who assured us this was going to be looked into.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Staff did not always treat people in ways which were dignified.
 - We observed staff administer a person's medication by injection at the lunch table in front of others. There was no privacy screen or curtain to protect their dignity. We also observed 1 person going in and out of people's rooms whilst they were asleep without any staff observing them or knowing where they were.
 - Some staff were seen completing tasks for people, such as helping them eat and stand. However, there was very little interaction whilst completing these tasks. Staff were often observed standing by people when they were sitting in chairs and not attempting to make conversation with them.
- staff discussed examples of how they provided dignified care. However, this was not always clearly recorded in care plans or daily logs.

We made the provider aware on day 1 of some of our observations, and they immediately took action to ensure processes were in place to improve this.

Supporting people to express their views and be involved in making decisions about their care

- We could not always tell from looking at care plans whether people had been involved in decisions about their care. There were no best interest meetings documented for people, so we were unable to establish if decisions were being made in people's best interests.
- We did hear staff asking people what they wanted for lunch, and if they needed any help with anything.

Ensuring people are well treated and supported; respecting equality and diversity

- People we spoke with and a visiting relative told us they liked the staff team and felt they were caring and kind. Comments included; "They're [staff] lovely, the lads and lasses are very nice to me, they're friendly I couldn't get on with my life before I came here, "I like it here, the food is nice, they [staff] are kind" and "It was a difficult decision [placing relative here], but this place is unique and remarkable. The staff are amazing."
- People were supported to follow their cultural heritage. For example, 1 person got weekly visits from a member of their community and were provided with specific food they were accustomed to. Other people were supported to have weekly communion visits if this was something they chose to partake in.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People mostly received care that was completed in a way that was meaningful for them. However, there were some areas which required improvement. For example, some people's care plans around their mental health needs did not clearly contain what strategies to use to help them when they became anxious.
- One person was given medication as a first resort to helping them with their anxieties. There was no evidence other forms of support or intervention had been considered before administering medication.
- Other information in relation to people's personalised needs was either incomplete or missing. For example, 1 person had a wrongly assessed falls assessment, which meant they had not been referred to the falls team when needed. Another person required food and fluid charts to help support them with their dietary needs. However, these were not in place.
- People did not always have access to equipment they needed to help manage or mitigate risks. For example, 1 person required an air flow mattress to help with pressure relief and reduce skin breakdown. However, they did not have 1 in place.

People were not always getting care which was personalised to their needs and choices. This was a breach of regulation 9 (1) (3) (a) (b) (c) of the health and social care act 2008 regulated activities (regulations) 2014

The provider responded straight away following our feedback on day 1, and when we returned for day 2, had taken action to rectify some of the concerns we had raised.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Some people had communication charts in place, however this was not consistent for all people we looked at. One person, who did not speak English had limited information in place with regards to how they might communicate their needs.
- We were advised the policies, procedures and service users guide could be presented in alternative formats to help peoples communication needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had been supported to maintain contact with their relatives throughout the pandemic.
- Due to limited information in people's care plans, we could not always be certain they were being offered activities which were relevant or meaningful to them.
- On day 1 and 2 of our inspection, there was limited interaction and activities for people, however the provider told us they were advertising for an activities coordinator.

Improving care quality in response to complaints or concerns

- There was a process in place for people and visitors to follow if they wanted to make a formal complaint to the home manager or provider.
- There was no system to formally log complaints, so we were unable to track if complaints had been appropriately responded to. We raised this with the provider who was in the process of implementing a more robust formal process to oversee complaints or concerns, however this was not yet in place.
- People we spoke with told us they knew how to complain.

End of life care and support

- End of life care and support preferences were documented in a way which was respectful and meaningful for people.
- Staff had completed training on end of life care and support.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Inadequate governance and quality assurance measures meant that people were exposed to unnecessary risk and avoidable harm. The provider was not effectively assessing, monitoring and mitigating risks relating to the health and well-being of the people living at the home.
- Governance and monitoring systems had failed to identify some of the issues we highlighted during day 1 of our inspection. For example, the concerns with the environment. Some medication audits were missing, and care plan audits had not taken place which would have identified that food and fluid charts were not in place for some people who required them. More robust audits would also have picked up on some of the inconsistent information in care plans and risk assessments.
- The quality and safety of care was not effectively monitored. There was no oversight of incidents and accidents, therefore it was unclear if lessons learnt were acknowledged.

The provider failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider shared a new audit tool they had devised which appeared more robust and focused on lessons learned and how mitigation processes could be improved.
- While we acknowledge this has now been put into place, we were not assured that without our inspection some of the serious concerns we identified on day 1 would have been picked up through the provider's own governance systems.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We were not always assured that a positive, person-centred, inclusive approach to care was being achieved.
- Areas of risk were not being monitored and the health and well-being of people living at the home was not routinely assessed. This had improved when we returned for day 2 of our inspection, and people had more detailed risk assessments in place.
- Due to some of the records being inconsistent or missing we could not always be sure people's care plans were tailored to suit them.

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 and temporary home manager understood their role with regards to being open and transparent about issues at the service. They had clear plans in place following our inspection to address any concerns we had identified.
- We felt assured following our feedback that action would be taken to address issues and have since been sent an action plan of how the provider will do this.

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

- The home worked in partnership with other external agencies and people received care and support from external professionals such as speech and language therapists.
- Some staff told us there was a disengagement between them and the agency staff, which the manager was trying to address.
- Team meetings took place, and people were routinely asked for feedback regarding the home verbally, however this was not always recorded.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Some people were not always getting support which was appropriate to their needs and in line with their preferences.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Records did not fully explain what decisions people could make for themselves. There was limited best interest processes in place for people when decisions were being made regarding their care and support.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People did not receive covert medication correctly. Risk assessments were poor around diabetes, positive behaviour support and epilepsy. There was also no analysis of incidents and accidents, therefore missed opportunities to mitigate harm.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	Some incidents had not been referred to safeguarding in line with policy and procedure

in order to keep people safe from harm.

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

Governance systems were not robust. Some audits were missing, not in place or did not identify shortfalls in service provision.

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff did not have any formal training to support people with enduring mental health needs or people with learning disabilities.