Hill Care 1 Limited

Halton View Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 13 and 14 January 2016. This inspection was unannounced. The last inspection of this home was carried out on 7 May 2014 when it was found to be meeting all the regulations we inspected.

Halton View Care Home is a purpose-built residential care home providing personal care and accommodation for 64 older people. It is a two-storey property comprising of 64 single bedrooms located within three separate units, all having en-suite toilet and shower facilities. There is a range of communal space's including: lounges; dining rooms and sitting areas. Toilet and bathroom facilities are dispersed throughout the building. There is a car park provided for visitors and staff.

The home was divided into three units. The ground floor unit accommodated 28 people. The upper unit had two separate units; a male only unit which was equipped to accommodate 13 people and a further unit which accommodated up to 23 people who were living with dementia. At the time of the inspection there were 61 people using the service.

There is a registered manager at Halton View. 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.

We saw that care records contained care plans and assessments pertaining to health and well-being, these were individualised depending on need.

People were actively supported to access the community. The home arranged for people to be involved with community activities as part of their daily living skills.

Staff understood the Mental Capacity Act 2005 (MCA) regarding people who lacked capacity to make a decision. They also understood the Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily.

We saw that staff supported people and we saw caring interventions. Staff told us that they observed people's body language and facial expressions to support their communication.

Staff told us that management was approachable and would listen to the concerns of staff and take necessary action if required.

One visiting heath care professional told us that staff contacted them when they had any concerns about people's health. They said that staff took notice of any advice given and acted on it with immediate effect.

Recruitment practices were thorough, appropriate and safe. Rigorous pre- employment checks ensured that only suitable people were employed. Staff training was up to date and staff received supervision and appraisals.

Relatives told us that their family members had the correct level of well trained staff supporting them. We reviewed the most recent staffing rotas. There were sufficient staff on duty to meet the assessed needs of the people who currently lived in the home.

We saw that the service assessed peoples' nutritional needs and had developed a varied menu. People told us that the food was good, not too fancy- but very tasty.

The registered manager had robust systems in place to monitor the quality of the staff and the services provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff told us they understood how to recognise abuse or potential abuse and
knew what to do if they had any concerns.

There was enough staff to meet people's needs.

There were effective systems in place to provide people with their medicines
as prescribed and in a safe manner.

Is the service effective?

Good

The service was effective.

The home assessed and monitored people's health care needs and worked closely with health care professionals to promote people's health and well- being.

Staff understood how to apply the deprivation of Liberty Safeguards (DoLS) to ensure people were not restricted unnecessarily.

People received care from appropriately trained staff.

Is the service caring?

Good

The service was caring.

People who used the service, their relatives and health care professionals told us the service was kind and compassionate.

There were caring relationships between the people using the service and the staff supporting them.

People were able to express their views and were involved in decisions about their care.

People's privacy, dignity and independence were respected.

Is the service responsive?

Good

The service was responsive.

People received prompt support when it was required.

People's care and treatment was planned and delivered in a way that treated them as individuals and met their needs. People were able to take part in activities which interested them and reflected their preferences.

Is the service well-led?

Good

The service was well-led.

There was an open, caring atmosphere with an emphasis on team work and care which treated people as individuals.

The registered manager had identified areas for improvement and was carrying out the necessary actions.

Systems were in place to monitor and improve the quality of the service provided.

Halton View Care Home

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 checked 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.

The inspection took place on 13 and 14 January 2016 and was unannounced.

The inspection was conducted by two adult social care inspectors on the first day. One adult social care inspector returned on the second day to speak with the registered manager and look at documentation relating to the quality assurance systems used within the home.

As part of our inspection planning we reviewed the information that we held about the home including statutory notifications received from the provider, these statutory notifications include important events and occurrences which the provider is required to send to us by law. We reviewed previous inspection reports and we contacted the local authority contract monitoring team to gather further information. On this occasion we did not request the provider complete the Provider Information Return (PIR). The PIR is a form that asks the provider give some key information about the service.

During the inspection we observed staff interacting with people who lived in the home. We spoke with the registered manager, deputy manager, area manager, an administrator, seven care staff, maintenance staff and two ancillary staff. We also spoke with two visiting health care professionals.

We spoke with twenty six people who used the service and five of their relatives.

We also 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 looked at records including six care files as well as five staff files and audit reports.

We looked around the building and facilities and by invitation, looked in some people's bedrooms.

Good

Is the service safe?

Our findings

People told us they felt safe within the home. Comments included, "I am fine here. They make sure I am safe and looked after properly" and "They (staff) always check on me to make sure I am safe and I am never frightened since I have been here".

We saw the service had a range of policies and procedures to keep people safe. These included safeguarding policies and whistleblowing procedures. Staff told us that they had received training in safeguarding vulnerable people and in Whistleblowing and records confirmed that training had been provided to all staff employed by the home. Records also identified that the service complied with the legal requirements to notify The Care Quality Commission (CQC) when there was an allegation of abuse.

Staff were aware of the risks to people of avoidable harm and abuse. They knew about the different types of abuse and were able to give us examples of signs and indicators they looked out for. They were informed about their responsibility to report any concerns, aware of the procedures to follow and confident that any concerns or allegations would be dealt with by the registered manager. They were also aware of contacts in outside organisations where concerns about people's safety could be raised if necessary.

The home had risk assessments and procedures in place to follow in the event of an emergency such as fire. Staff were aware of these and of how they should respond if the fire alarm sounded. The fire evacuation plan took into account the individual needs of people to include mobility issues.

Other risk assessments identified risks including those associated with first aid, activities and specific areas of the home such as the kitchen and laundry. The assessments included a definition of risk, the likelihood of it occurring, the severity of its effect and control measures in place to manage and reduce the risk.

If accidents or incidents did occur staff completed a standard form which was reviewed and followed up. Steps were taken to prevent the same thing happening again and follow up actions were recorded. These included any treatment of wounds sustained in the accident and a period of observation in the days following a fall.

The five staff files looked at identified that recruitment procedures ensured that applicants were checked for their suitability, skills and experience. Suitability checks included a robust interview, checks for criminal histories and following up references prior to a job offer being made. We saw records that showed arrangements were in place to monitor staff performance and carry out formal disciplinary procedures if required. In all the files we looked at we saw that either a Disclosure and Baring Service (DBS) check, or the authorisation number, which confirmed a check had been undertaken, was present. These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Two references were also seen on each file, in line with the provider`s policy. We looked at the dates on references and DBS checks and they confirmed that no new employee had started work before all the required security checks were completed. Application forms and interview questions were also

seen. The interview included questions related to safeguarding of vulnerable people. Staff were provided with a copy of the staff handbook and an induction log.

The registered manager had determined staffing levels based on assessed dependency levels, feedback from people, their relatives and staff. Staff rotas and other records showed staffing levels were consistent with eight care staff and two seniors on duty from 8.00am until 8.00pm and three care staff and two seniors from 8.00pm until 8.00am. One care staff was on duty 8.00am until 2.00pm. Care staff told us they were always busy but there was always the right number of care staff on duty. One visiting relative told us that staffing was fine and they felt that staff always had enough time to provide safe care in an unhurried way. We saw staff were able to carry out their duties in a calm, professional manner. If two care staff were needed to attend to a person, there were two available. We noted that the registered manager and her deputy were also on hand to assist if the need arose. We noted that the home had a very low staff turnover. Staff told us that this was because they liked working in the home and worked well as a team. The registered manager told us that after a recent relatives meeting had been held it was decided that an extra staff member was needed between 8.00am and 2.00pm on the upstairs unit and this was quickly agreed and implemented.

Medicines were kept safely in a lockable trolley within a locked room. Controlled drugs currently prescribed to people living in the home were stored in a special cabinet. Controlled drugs are prescribed medicines that are controlled under the Misuse of Drugs Act 1971. They require specific storage, recording and administration procedures. There were appropriate arrangements to store medicines within their recommended temperature ranges and the expiry dates of medicines were checked. The administration of medicines was recorded including the administration of creams as part of people's personal care. Records showed that a local pharmacy supplied the medicines for the home and medication training had been provided for all the staff who were responsible for the management of medication. We spoke with the senior carer who was responsible for the medication administration at the time of our inspection. She was able to demonstrate clear knowledge and understanding of all aspects of medication management. We looked at the administration and recording of medicines. We looked at a sample of the medicines and checked them against the Medication Administration Records sheets (MARs). We saw evidence which indicated that medicines had been administered and recorded correctly. Staff spoken with knew the importance of giving medicines at the prescribed time, for example, some medicines were given once a week and others were required an hour before food.

Effective infection prevention and control measures were in place to minimise the risk of the spread of infections. Systems were in place for managing cleaning materials and laundry. The home was visually clean and free from any unpleasant smells. We saw staff using disposable aprons and gloves as appropriate. There were adequate supplies of gloves and aprons available to ensure they could be disposed of between specific tasks.

The home employed a maintenance person who carried out all essential service checks and dealt with any maintenance issues. We spoke with this person who was able to provide all documentation including fire detection and alarm equipment, fire drills, water testing, room temperature checks and legionella testing. We saw that there was a policy in place for supply failures such as gas or electricity and emergency contacts identified in the event of essential service failures.

Good

Is the service effective?

Our findings

People told us that staff had the skills and knowledge to provide effective care and support. Comments included "Staff know what they are doing and they do it well", "The staff are well trained, they always seem to know what to do" and "They (staff) get lots of training in all sorts of things. That means they can do everything properly".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to refuse care and treatment when this is in their best interests and legally authorised under MCA. The authorisation procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). The registered manager kept a log of everyone who was applicable for a DoLS. This included the date the DoLS was requested, date assessed, the date of the outcome and the expiry date. We saw there were currently two people subject to a DoLS authorisation and 12 applications had been submitted and were awaiting actions from the local authority.

Staff had a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation. Documentation on people's care plans showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

The registered manager had a list of training courses that they deemed to be mandatory. These included safeguarding, moving and handling, dementia care, MCA and DoLS. Each mandatory training course had assigned renewal frequencies and was tracked by the registered manager as well as regionally to ensure the staff had the required knowledge and skills to provide effective care and support. We saw that where required, additional training was delivered depending upon people's needs. Staff told us they were satisfied they received appropriate and timely training. We found that the registered manager had an induction training programme that was designed to ensure any new staff members had the skills and knowledge they needed to do their jobs effectively and competently. Following this initial induction and when the person actually started to work, they shadowed existing staff members and were not allowed to work unsupervised until the registered manager considered them competent to work on their own. Shadowing is where a new staff member works alongside either a senior or experienced staff member until they are competent and confident enough to work on their own. Staff spoken with confirmed that they had completed their induction and had shadowed a senior member of staff when they had started working at the home. The training matrix confirmed that all mandatory staff training was up to date. Staff told us that they were encouraged and supported to undertake extra training of their choice such as dementia and end of life care.

We reviewed the process for supervision and appraisal and also viewed a selection of completed documents. We saw that supervisions were carried out two/three monthly, however we noted that whilst all current supervisions were up to date not all past sessions had been recorded. The registered manager told us that there had been a backlog with a small number of staff due to absence but all current supervisions

had been completed. Staff spoken with told us that they received regular supervision and found it useful. Supervision sessions between staff and their line manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs.

Staff sought people's consent for care and treatment. Where people were able to consent, this was documented in care plans. People signed their consent forms if they were able to do so. Family members were involved in discussions when appropriate. Consent forms were in place for both day to day care and support and for other decisions such as whether to use bed rails if the person was at risk of falling from their bed.

Staff were able to tell us about the individual needs of people they were supporting. For example, what time of day people preferred to shower or have a bath, how they liked to be dressed and what they enjoyed doing during the day.

We looked at five care records, which provided evidence that people had access to health care professionals such as GPs, podiatrists, opticians and dieticians. People had health care plans in place which monitored any risk relating to people's physical health. Health care plans contained guidance for staff on people's diet and nutrition which included monthly weight charts and any dietary requirements such as sugar free foods and special diets form people who were lactose intolerant or diabetic. People's care plans and records demonstrated the home worked closely with dieticians and speech and language therapists to ensure people received the appropriate care and support. People were supported to maintain their physical and mental health and had access to health and social care professionals when required. Records showed the support people required to meet their physical and mental health needs and where concerns were noted we saw people were referred to appropriate health professionals as required. Records of health care appointments and visits were documented within people's care plans so staff were aware of any treatment required or advice given. Comments from health care professionals were most positive and included "The manager is a strong leader and is quick to contact if they have any concerns".

People told us that they liked the food. Comments included; "Food is OK "and "It is alright, I like it". We observed people during the lunch time meal. The menus were displayed in written form in the dining room, choices were available. Most of the people dined in the dining areas; however people if they wished, could dine in the privacy of their own room as was their choice. One person told us, "Drinks and snacks are always available and you can generally get anything you like at any time you want it". Staff told us that the dining experience was flexible to suit the needs of the people who lived in the home. They said that most of the people ate what they wanted, when they wanted it. However, they also said that the lunchtime and evening mealtimes were served at a given time to enable people to have a structured approach to dining if they choose to do so. We observed people enjoying drinks and snacks throughout our visit. Staff told us that although jugs of juice and water were readily available they were not left on display in certain areas of the home for safety reasons; they knew when people wanted a drink and would ensure they were provided with a drink whenever they requested one.

Staff understood people's dietary preferences and people's dietary needs were assessed so people were offered a suitable diet. For example, people's likes and dislikes were requested on admission as well as any allergies or special dietary needs. This information was held on the care files and in the kitchen. One person who lived in the home told us that a relative joined him for lunch some days and they were able to have 'a nice meal and a chat together'.

A tour of the premises was undertaken; this included all the communal areas including the lounges and

dining areas along with bedrooms with people's consent. The home was well maintained and there was appropriate signage to the bathrooms and communal areas. We noted that on the upstairs units, bedroom doors had been painted in bright colours and benches and effective lighting had been positioned along the corridors to assist people with their orientation.

Good

Is the service caring?

Our findings

People who lived in the home and their relatives told us told that staff were nice and caring. Comments included "The girls (staff) are lovely. They look after us well", "The staff are lovely, kind and caring" and "We are very happy with the care here it's the best place we have ever seen". Comments from a relative of a person who had lived in the home was most positive. They said "The staff here are faultless and superb. They could not have done more. We lost her (relative) last night, but we were allowed to camp out here all week. They have done everything they could and have even looked after us all as well".

During our visit the general atmosphere in the home was calm and relaxed. The people living at the property were observed to be comfortable and relaxed in their environment and were able to follow their own plans and preferred routines. Staff were attentive to the diverse needs of the people living in the property and were noted to communicate and engage with the people they supported in a respectful, dignified and caring manner. It was clear from the interactions between staff and people who lived in the home that staff were aware of people's need for privacy and dignity. It was observed that any personal care was undertaken in privacy and staff were seen to refer to people by their preferred name, ask people what they wanted, rather than assume their needs, which demonstrated respect and dignity for the people they supported. Staff knocked on peoples doors before entering and we noted that all engagement between staff and people who lived in the home was undertaken in a kind and courteous manner. We observed a care staff member assisting a person to walk with the aid of a walking frame. We saw that they encouraged the person and supported the person to maintain their independence. The carer was very patient and said "No need to rush, you are doing very well, you are walking well today that's great". We observed a person being helped to mobilise with the use of a hoist. Staff chatted to them throughout and explained exactly what they were doing and why. Their actions were dignified and not rushed. We saw a small laminated note on the door of a person who used the service saying "I am busy with a member of staff, please come back later". Staff told us that this ensured people's privacy and dignity was respected.

Staff supported people and their families with care and compassion. For example we observed three people who lived with dementia becoming anxious and disorientated. The staff immediately responded in a calming and soothing manner and used diversion therapy to alleviate people's distress.

We noted that some people who used the service required support to express their views and preferences. Staff told us there was an effective system in place to request the support of an advocate to represent their views and wishes. Records in care plans confirmed this. This demonstrated that people who lived in the home were supported to express their views and wherever possible be actively involved in making informed decisions about their care.

At the time of our inspection end of life care plans were in place for some people who lived in the home. Staff showed us the processes and resources available to individuals who required this specialist care. There were regular assessment and reviews by nursing and medical staff and individual care plans which would outline the end of life preferences of the person and their family.

Visitors were able to visit whenever they wished and to spend time either privately in their relatives own room or in the communal areas as they chose. It was evident from speaking to people living at the home, relatives and also from the observations on the day that staff at Halton View encouraged visitors to visit at any time.

Good

Is the service responsive?

Our findings

People told us that they were satisfied with the care and support they received and said that staff responded quickly if they needed support. Comments included "We have alarms in our rooms and staff come quickly if we call", "Staff come to me when I call" and "The staff are always on hand to help".

The staff used an admission checklist to make sure that admissions were coordinated, individualised and focused on the current need of the person. We saw that staff shared important information with other professionals about people when they were being admitted to the home or transferred to hospital to make sure their care was coordinated. Comments from a visiting health care professional identified that the service was responsive to peoples changing needs and shared need to know information with other professionals to ensure effective care was provided which was responsive to changing need. Comments included "This home provides excellent quality care and would 'pass the mum test', which means it provides kind, considerate, responsive services".

Staff worked with people who lived in the home and people's relatives to establish effective methods of communication so that individuals could be involved wherever possible in their care and treatment. Each person had a plan that was personal to them. These plans were used to guide staff on how to involve people in their care and provide the care they need. For example if a person who lived with dementia could not verbally communicate, other communication methods were used. These included verbal and non- verbal methods to include pictorial cards. These communication aids were based on professional guidance. The plans were also used to guide staff on how to involve each person with their care plan and provide the care and support they needed and requested. All of the plans we looked at held sufficient detail to enable the person reading it to provide care appropriate to the wishes, choices and capabilities of each individual. The plans were reviewed regularly so staff knew what changes, if any, had been made, especially when the GP or visiting professional had visited. Staff used recognised tools for people at risk of: pressure sores developing, risk of falls, nutritional status etc. Assessment tools were completed on a regular basis by staff to help provide the most appropriate updated guidance and care for each person living at Halton View. People told us that their care plans accurately reflected the care they wanted to receive such as when to have a bath, what level of personal care they requested and what activity they wanted to take part in.

People's wellbeing was promoted by appropriate activities and entertainments. People told us that they enjoyed activities such as a reading group, dominoes and chair exercise. We saw that the home employed an activity co-ordinator who arranged activities and entertainment for the people who lived at Halton View. Staff told us that they had also received training from the local authority Later Life Activity Team to ensure they were also able to provide activities and stimulation to address all the diverse social needs of people who lived in the home. We saw the activity programme which identified that entertainment such as singers and musicians was provided at least twice a month. We saw that other activities such as race nights, sing a longs, choir practice, visits to the Alzheimer's café and the Vintage Kitchen were arranged on a regular basis. Relatives of people who lived in the home told us that the home provided lots of activities to ensure that people who lived there were 'motivated, stimulated and enjoyed their daily life'. Throughout our visit we saw

people chatting, reading or participating in activities in a very pleasant environment.

Staff told us that the home used 'rummage boxes' and other forms of reminiscence to enable people to reflect on their past and gain enjoyment from recalling their memories.

People were aware that they could make comments or complaints about the service formally or informally. They said they would have no issues about raising concerns with the registered manager or any staff member. Visiting relatives were complimentary about communications with the registered manager and how she responded to comments. One relative said "She (manager) is an angel. She takes on board anything you say and constantly strives to improve the lives of the people who live here".

The provider's complaints procedure was displayed at the entrance to the home. There was a complaints file that showed that any formal complaints made about the home were quickly dealt with as per the provider's policy and procedures.

Good

Is the service well-led?

Our findings

People told us that the home was well managed by a person who was easy to talk too and really cared about them. Comments included "She (registered manager) is so easy to talk to. She really cares about the home and the care we get. She asks us all the time if everything is OK" and "The manager is always around to speak to. She encourages us to speak our mind even if it is about something we don't like".

The registered manager, staff and the provider undertook regular quality assurance audits to help check the quality of care being provided at the home and that the home was a safe environment for people to live in.

The registered manager told us that their vison was to make sure people were cared for in a "lovely, warm, safe friendly environment". Staff told us that during meetings and supervisions team work was always on the agenda. They said that the registered manager emphasised team work and delivering care and support that treated people as individuals. A relative of a person who lived in the home told us that their relative's individual needs had been discussed, addressed and implemented by way of "excellent team work".

There was a clear management structure which identified roles, responsibilities and accountability for all the staff who worked at the home. Staff spoken with were fully aware of their line management and their own areas of responsibility to include lead roles in areas such as infection control, activities, cleaning and dementia care.

The registered manager and her deputy made themselves available to people and staff almost every day. This was well received with positive comments made by a number of people and their relatives. We saw that the registered manager had an action plan for improving the service. It identified actions to be taken, who was responsible, and progress so far. They told us they were supported by the provider in making the changes they had identified.

There were systems in place to request feedback on the quality of the service provided from people, their families and representatives and from visiting service providers. We saw the results from a survey undertaken 2014/5 and noted that all responses were positive about the staff and services provided.

There was a system of internal checks and audits in place to monitor the quality of the service. The audit timetable included clinical governance, resident dependency, medicines, care files, infection prevention and control, health and safety, equipment, cleaning and activities. In addition unannounced spot checks were undertaken by the registered manager and her deputy when they 'walked the floor'.

The area manager also conducted a monthly audit of identified areas which included pressure areas of the skin; weight loss and discussions with staff members and people living at the service.

Records identified that meetings were held regularly. We looked at the agenda for the December 2015 staff meeting and noted that meetings were held at suitable times for the morning staff, for the afternoon staff and for evening staff. This ensured that all staff were able to attend staff meetings. Agenda items included;

safeguarding, unit and room checks, care of residents hair and nails, training and pressure care. Staff told us that they had regular meetings and were kept up to date in the running of the home. They told us they felt confident to speak up in meetings to offer suggestions or ideas.

People who lived in the home were encouraged to express their wishes in relation to outings and the general day to day activities provided. We saw that resident meetings were held on a regular basis. We viewed the minutes of the meetings held in October and November 2015 and saw that discussions included choice of menu, establishing a group to meet with the chef, care provision and activities.