HC-One No.1 Limited

Altham Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Altham Court Care Home is a care home providing personal and nursing care to 36 people at the time of the inspection. The service can support up to 48 people in one adapted building.

People's experience of using this service and what we found
People were at risk of unsafe care as care plans and risk assessments had not been kept up to date. This meant staff may be unable to provide care that was relevant to their current need as their records contained information that was not relevant.

We were told choking risks had been identified before the inspection. However, lessons had not always been learnt, as at inspection we found some people's needs had not been recognised around their choking risk.

Staff were trained and understood the process of escalating safeguarding concerns. However, we found evidence of one safeguarding concern that was not escalated as appropriate.

People were supported by staff that had been safely recruited. However, we were not fully assured that enough numbers of staff were available, to ensure people's individual care needs were consistently met.

Whilst there were attempts to get feedback from relatives and people by the provider, this could be improved. Generally, we heard people were happy with their care and they thought the registered manager was nice and approachable. External health and social care professionals felt the registered manager was keen to engage with them and was proactive in their action.

Infection prevention and control measures were identified and actioned by the provider.

There was a lack of oversight of the service. Processes and quality assurance systems did not identify that records did not always show people's current support needs. The registered manager was not known to all people and relatives but where people knew who the registered manager was, feedback about them was generally positive.

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 requires improvement (published 20 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about choking risks. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-Led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Altham Court Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to safe care and treatment, and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Altham Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Altham Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and one relative about their experience of care provided. We spoke with eight members of staff including the area director, registered manager, nurses, senior carer and carers.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. 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. We looked at training data and quality assurance records. We spoke with one professional who regularly visits the service and two other relatives.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Risks to people's health and welfare had not been fully assessed. People's care plans lacked in detail. Care plans for two people who were on oxygen therapy lacked information, for example about the rate at which oxygen should be provided and what staff should look out for in case of low oxygen levels.
- Diabetes care plans did not always contain enough detail. We identified one person whose target blood sugar range was not documented within their care plan or risk assessment. We spoke to nursing staff who provided different ranges that they felt were acceptable. This lack of consistency put people at risk of poor diabetic control.
- Skin integrity was not always assessed and documented sufficiently. For a person recently admitted who was at high risk of skin breakdown, the pressure area risk assessment chart had not been completed as policy required.
- Food and fluid charts were not always appropriately used. In one person's daily care notes variable days of "Very low" or "Zero" fluid intake and a repeatedly low appetite and food intake was recorded. There was no food or fluid chart in place for staff to assess how much this person was offered or received. Poor care planning for the intake also put people at risk of not eating or drinking enough.

Learning lessons when things go wrong

- Lessons were not always learnt when things went wrong. Before the inspection we were told all people who needed a special diet received this. We were also told that care plans were updated to show the support with eating and drinking that every person needed. At inspection we viewed the service's audits of care plans, which identified one person's modified diet had been wrongly recorded but the care plan had not been updated following this. We also identified one person received regular food who should have received pureed foods. This put people at risk of harm.

Failure to not always identify and manage risks associated with people's care in a safe way was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has been responsive to the concerns identified and has put steps in place to reduce the risk going forward, such as producing updated care plans and risk assessments. We were also told PEEPS have been updated and all people now have photos in place and the provider has educated staff about the importance of appropriate food consistency.

Staffing and recruitment

● We could not be assured that the service always deployed enough staff to keep people safe and ensure their needs were met. Staff told us there was a shortage of staffing at the service. One staff member said, "Some nights there is just two carers, you are just rushed off your feet - you just can't do it."
● Where people stayed in their bed's, there was insufficient staff to meet people's need to reposition them. If people were not repositioned regularly enough, pressure builds up and this can lead to skin and tissue damage. We saw charts for someone who should be repositioned every four hours, not getting repositioned for eight hours on one occasion and 18 hours on another. When asked about meeting the required frequency of repositioning, one staff member said they were unable to do this, "Especially not when you are short staffed."
● Call bell response times were sometimes lengthy. Records showed people had to wait up to 40 minutes for their bell to be answered. One person at the service told us, "'When you buzz you have to wait and wait for them to come." One relative said, "There can be long waits with the call bell and [person] keeps pressing it." Delays in responding to call bells may mean people do not get support in the timeframe required.

Failure to provide sufficient staff numbers was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff that had been recruited safely. The process included exploring employment gaps, obtaining and verifying references and carrying out a Disclosure and Barring Service (DBS) check to ensure the applicant was suitable to work with vulnerable people.

Using medicines safely
● Temperature checks for medicines kept inside the fridge was not actioned when temperatures fell outside the range, as recorded in the safe storage of medicines procedure. This put people at risk of their medicines being damaged as they were stored incorrectly.
● People had their medicines administered by staff trained in safe medicine practices and who had their competencies checked regularly by senior staff. The electronic care system supported this, for example, by highlighting if medicines had not been given.

Systems and processes to safeguard people from the risk of abuse
● Allegations of abuse were not always escalated. We heard from one person who had put in a complaint to the service that staff were "Slapdash and rough" when moving them. This was not escalated to the local authority safeguarding team at the time but has been investigated by the registered manager.
● Staff spoken with were knowledgeable about how to raise a safeguarding concern, which included informing the management team and outside agencies, such as the Care Quality Commission (CQC) and the local authority.
● Staff had received training in safeguarding.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Audits were not always completed. For example, we found there were delays in staff response to call bells. However, there was no systems and processes in place to review and identify where improvements could be made. We were told that this was to be discussed in the daily meeting and a system was introduced to alert the registered manager to lengthy waits.
- Where audits were in place, they did not always pick up the concerns we identified on inspection. For example, we identified concerns about skin care, fluid and oxygen management which were not detected by the processes already in place. This had also not been identified by the provider's checks on the audit processes carried out at the service.
- People were put at risk because it was not always identified when policies were not being followed. For example, one person had no wound care plan for a month from when the wound was first identified. The providers policy stated all changes should be recorded as soon as possible after discovery. The delay in having the wound care plan in place, put people at risk of poor wound care.
- The registered manager had poor oversight of training and training needs had not all been identified. For example, no staff had training in stoma care despite two people having stomas.
- The registered manager did not have effective oversight of staffing levels. The tool used to calculate the number of staff required was held with head office and not with the registered manager.

The lack of systems to assess, monitor and improve the quality and safety of the service was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives told us they would like more opportunity for feedback. We saw evidence of a residents meeting, but the number of people confined to their beds may have meant people missed the opportunity to take part in the residents meeting. People and visitors were able to give feedback by a computer in the hallway, but the uptake of this was low.
- Staff did not always feel confident in the registered manager. Two staff members told us they reported concerns to the registered manager in staff meetings and handovers that were not acted on. One said "She is nice and approachable. But that is it, then it is gone."

● Regular staff meetings, supervision of staff and a recent staff survey has taken place. Staff told us the supervisions were helpful and the staff survey was generally positive.
● The equality and diversity policy was in place. The culture at the service respected and promoted diversity.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● People and relatives did not always know who the registered manager was. Where people did know who the registered manager was, there were mixed views about them. One relative said, "the communication from the manager could be a little better." One person said, "the manager is very nice, and if you are not satisfied with something, she sorts it out" and another said, "I haven't had to complain. I'm sure they'd listen if I did."
● The providers visions for the service were clear, and person centred, and we found staff were kind in their interactions with people and relatives. However, the governance systems in place were not always effective in ensuring people's individual needs were known and responded to.

Working in partnership with others
● The local pharmacy and the registered manager did not always have an effective system in place for medicine ordering. We were told by one staff member this resulted in some people being short of medicines for three days. This was also noted in the audit of medicines where they failed on the ordering and delivering part of the medicines audit in September and October.
● Partnership agencies found the registered manager approachable and keen to work with them to ensure they aren't missing anything. One professional told us the registered manager is "very proactive to engage."

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. Regulation 18 (1) (2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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	The provider had failed to effectively assess and mitigate risk to ensure people received safe care and treatment, this put people at increased risk of harm. Regulation 12 (1) (2)

The enforcement action we took:

Issued a warning notice to provider and RM

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems were not used effectively. There was a lack of oversight of people's care. Regulation 17 (1) (2)

The enforcement action we took:

Issued a warning notice to registered manager and provider