Hill Care 1 Limited

Halton View Care Home

Inspection report

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Date of inspection visit:
01 August 2017
03 August 2017

Date of publication:
20 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection of Halton View took place on 1 and 3 August 2017 and was unannounced.

There was no registered manager at the time of our inspection. The service employed a manager who had applied for registration with the Care Quality Commission. 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.

Halton View Care Home is a purpose-built residential care home providing personal care and accommodation for 64 people. At the time of our inspection there were 63 people living at the home. It is a two-storey property comprising of 64 single bedrooms located within four separate units, all having en-suite toilet and shower facilities. There is a range of communal spaces 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.

We last inspected Halton View in January 2016 and rated the service 'good' in all domains and 'good' overall.

We received some information of concern from the Local Authority with regards to a serious incident at the home where a person fell and passed away a short time later in hospital. The feedback we received from the Local Authority and our own requests for information indicated that we would need to go and inspect to ensure other people living at the home were not at risk. We wanted to examine what strategies were in place to monitor and supervise people who were at risk of falling to ensure that other people living at the home were kept safe. We also wanted to check whether the staff numbers were sufficient to support people and whether staff had received the necessary induction to enable them to fulfil their roles effectively.

This inspection was 'focused' in response to concerns in that we only looked at two domains; Safe and Well-led. The domains 'Effective', 'Caring' and 'Responsive' were not assessed at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Halton View Care Home' on our website at www.cqc.org.uk.

During this inspection we found that the service was meeting the needs of people and was keeping people safe from harm specifically in relation to falls prevention although record keeping did not always reflect this. The service had taken positive steps to improve their risk management practices following the above serious incident.

On this inspection, we saw that many people living at Halton View were mobile with the assistance of an aid and therefore we considered that they were more susceptible to accidental falls. We found that the service had taken appropriate measures to mitigate this risk as far as possible and that people who were in danger

of falling had the necessary risk assessments in place. However, we found that records were not always accurate and meant that the level of risk was not always captured correctly. We have made a recommendation about this.

People we spoke with told us they felt safe living at Halton View. People told us and our observations confirmed, that there were sufficient numbers of staff on duty to meet people's needs.

We saw evidence of good quality assurance procedures which had been developed to meet the needs of the service. The service was able to evidence a series of robust audits carried out by the area manager to monitor and improve standards in the home.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements.

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.

Risk assessments were not always completed accurately and some wording was confusing. We have made a recommendation concerning this.

The service had taken appropriate and preventative action to care for people who were at risk from falls.

People we spoke with told us they felt safe living at Halton View.

There were sufficient numbers of consistent staff on duty to meet people's needs.

Is the service well-led?

Good

The service was well-led.

Systems in place to monitor the quality and safety of the service were effective and included an audit system to analyse falls and capture trends.

Some documentation and records generated at provider level was not easy to follow and led to confusion among staff when scoring risk.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements.

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 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.

This inspection took place on 1 and 3 August 2017 and was unannounced.

The purpose of this inspection was to check if the provider was managing risks to people effectively following recent concerns regarding a high rate of falls at the service; and a person's death following a fall.

Before our 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. As this was a focused inspection, on this occasion we did not request the provider complete a Provider Information Return (PIR). The PIR is a form that asks the provider give some key information about the service.

The inspection was carried out by two adult social care inspectors and an expert by experience.

During our inspection we spoke with the registered manager, the area manager, nine people living in the home and six relatives of people living at the home. We observed the lunchtime service and staff interaction with people who lived at the home. We looked at the care records for five people. We checked the quality assurance and auditing systems and other records relevant to managerial oversight and monitoring of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Halton View. Comments included; 'I am safe as I can be" and "I love it here now. I am safer here."

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. We found however, that not all risk assessments were completed accurately. For example some people's dependency assessments had been scored inaccurately. This was due to an inconsistency in the use of the term 'independently mobile'. Some staff had interpreted this to mean that the person had 'normal weight bearing' and did not require a walking aid, others interpreted this as the person was independent with a walking aid. This meant that the information within the risk assessments did not always provide staff with accurate information regarding people's needs. We discussed this at the time with the manager and they agreed that wording needed to be more accurate to reflect what support people needed with regards to their mobility. The manager was also in the process of reviewing care plans and risk assessments to ensure they clearly made the distinction between people who require one on one supervision and those who required general observation when mobilising around the home.

We also saw that some of the risk assessments contained errors with regards to the recording of information. For instance, one person's nutritional care plan recorded that they were at high risk of weight loss. However, the accompanying care plan advised that staff were to encourage snacks between meals and monitor weight gain weekly. This was inaccurate as the person's BMI chart showed they were obese. This information was confusing so we checked and saw the confusion was due to a scoring misinterpretation by staff when assessing BMI scores due to the format of the documents. The manager took immediate action to correct this.

A number of care files contained a pre-admission assessment which contained some incorrect information; this meant that the service was not always aware of people's needs from the point of admission. For example, we saw that one person had been assessed incorrectly on their mobility assessment. This meant that person was scored as medium risk of falls instead of high risk. However, we saw that the pre assessment process had improved in more recent admissions.

We recommend that the provider continues to review their documentation and updates their practices accordingly to ensure risks to people's safety and welfare are mitigated.

One relative we spoke with described the course of action the service had taken since their relatives fall. This included hourly checks which had been implemented by staff following the fall, and putting in place preventative measures such as a sensor mat. One relative said; "(Family member's) balance wasn't good. They (home) gave her a walking frame and it's much better now." Records showed this action was taken following advice from the occupational therapist.

The management team told us they planned to introduce an 'about me' document to give an up to date pen

picture of people's needs as they evolved.

We saw that incident forms were contained within care files and reflected when people had been involved in any accidents or falls. We also saw evidence of good after-care following a fall, including the hourly observations. The staff had considered preventative measures for those at risk of falling which included bed rails and the rationale for their use in line with the principles of the Mental Capacity Act (MCA).

In addition, we saw that the service had introduced further training for senior care staff in response to a recent increase of accidents (mainly falls) in the home. This included additional training in respect of; nutritional risk assessments, falls referrals and the management of accidents. This demonstrated the service's commitment to staff learning and development. In addition, the senior care assistants were provided with more in depth training as a result of the last serious incident, which included reporting and responding quickly when people did fall.

We saw that care plans contained Personal Emergency Evacuation Plans (PEEP's) and that these plans outlined where people required the use of a walking aid. This helps to ensure safe evacuation in the event of an emergency for those with mobility issues.

We looked at how the home was staffed and checked whether there was an over reliance on agency staff who may not be familiar with people's needs. Records showed that staffing levels were adequately maintained and that the service did not rely on large numbers of agency staff. This had decreased in the last few months. We saw if agency staff were used, the service ensured that they had had an appropriate induction which included fire safety, handovers and allocation, health and safety prior to caring for people The service has recently taken on a large number of new staff.

Both people and relatives of people who received a service felt that staff numbers were sufficient. Comments included; "There is always staff around. It's rare that we have to wait for anything" and "If I ring this (buzzer) staff come right away. They are never far away." Our observations confirmed this.

Good

Is the service well-led?

Our findings

There was a new manager in post who had been at the home since April 2017 and was in the process of becoming registered with CQC.

During our inspection the manager responded positively and openly regarding previous shortfalls in service provision. We checked to make sure that the systems in place in relation to the quality assurance process were effective.

We found that a range of audits and checks were in place and they were used to monitor the quality and safety of the service. The audit system was linked to our key lines of enquiries; safe, effective, caring, responsive and well-led; and covered areas such as, weight loss, falls, pressure areas and accident analysis. The recent Local Authority audit report was available for us to view, and we saw that some issues which were highlighted had action plans formulated along with a timescale.

We saw that the service was taking action to improve following a recent serious incident at the home and we spent time looking at what the service had put in place. We saw there was a record of monthly audits in respect of falls. This process ensured that trends were captured and identified that a high proportion of unwitnessed falls took place in the evening when lower staff levels were present. The service responded by changing the procedures around staff handover to ensure visual oversight of people in communal areas during handovers. The service also ensured that the daily staff meetings covered a new agenda item relating to falls. The service had implemented a senior care learning programme which covered reporting of incidents and actions. This meant that systems in place to monitor the quality and safety of the service were more responsive following lessons learned from previous incidents.

We also discussed that the format of the documentation implemented at provider level led to confusion among staff when scoring risk. The manager agreed to address this by way of further training for staff in scoring risk and also consideration to reformatting these specific documents. The service had introduced a new key risk document for people living at the home which contained a brief summary of people at risk and we saw evidence of this document within care files. This meant that it will be easier for new staff to access the most current, relevant information to enable them to support people safely.

The manager and area manager were available during our inspection visit and were described as very 'hands on' and approachable by staff. There was good managerial oversight and evidence of self-directed action plans to improve the service. The issues that we highlighted with the manager had largely been previously identified by them as part of their internal audit process which suggested that the internal auditing process was effective.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding Halton View Care Home.