Porthaven Care Homes Limited

Haddon Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Haddon Hall Care Home is a residential care home providing nursing and personal care to up to 75 people. The service provides support to older people, people living with dementia and younger adults. At the time of our inspection there were 69 people using the service.

People's experience of using this service and what we found
People did not always receive safe care. Some people had developed sore and broken skin and were not always receiving the appropriate care to make them better. Risks to people's safety were not always assessed or reduced. Staff were not always deployed effectively to make sure people received safe care. The registered manager had failed to report all safeguarding incidents to external safeguarding professionals.

The provider had failed to ensure the service was well-led. The registered manager had not always worked effectively within the provider's governance processes. Recent audits and risk meetings had not identified the risks to people's safety we found during this inspection. Staff did not feel listened to valued or respected. The registered manager had failed to complete an investigation into repeated staff concerns of unsafe care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The home was clean and free from malodours throughout. Staff wore Personal Protective Equipment and worked within best practice guidance to protect people from illness such as COVID-19.

Relatives consistently praised the hard-working, kind, caring and dedicated staff.

Immediately after the inspection the provider responded to our feedback and put measures in place to improve the safety of the care provided. They also carried out whole home audits to identify if there were other areas they needed to improve.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (Published 25 January 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to staffing levels. As a result, we undertook a focused inspection to review

the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of the 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 Haddon Hall Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to safety, governance, staffing and recruitment at this inspection. Please see the action we have told the provider to take at the end of this report. 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, which will help inform when we next inspect.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 timeframe 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 the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Haddon Hall 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 Health and Social Care Act 2008.

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
This inspection was carried out by five inspectors and two Experts 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
Haddon Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Haddon Hall Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited the location on three occasions, two of which were evening visits to review staffing levels. We reviewed care plans and records of care for 19 people. We reviewed multiple medicine administration records, governance records and three staff recruitment records. We spoke with four people and 21 relatives. We spoke with 23 staff including the registered manager, area manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to always check the COVID-19 status of visiting professionals. This was a breach of regulation 12(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Assessing risk, safety monitoring and management

- People were not always protected from harm.
- Some people had developed sore and damaged skin whilst living at Haddon Hall. The provider and registered manager had failed to ensure they always received the necessary care and treatment to promote their recovery. This left people with sore and broken skin that worsened.
- Where people were assessed as requiring a certain volume of liquid drinks every day to keep them healthy and prevent illness, the provider and registered manager had not always ensured they were supported to drink enough.
- One person had lost a significant amount of weight in one month. This had not been recognised as a risk to this person until we raised this during the inspection. This person's care records showed they had not eaten enough to maintain their weight.
- Where people were at risk of weight loss, they were not always supported to have their weight monitored more regularly.
- Where risks to people's safety were assessed, their care records did not always demonstrate they were protected from harm. For example, one person had difficulty swallowing but their care records showed they had eaten foods of a normal consistency. If this record was correct this would mean the person was at risk of choking.

Learning lessons when things go wrong

- The provider and registered manager had failed to ensure there were always investigations or lessons learned when people developed sore skin or lost weight.
- Staff told us they had repeatedly raised concerns with the registered manager that care was not meeting people's needs. There was no investigation or review of staff feedback.

Systems were not used effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately after the inspection we contacted the provider. They responded by addressing the safety concerns. We then visited the home again a week later and found people's sore and broken skin was healing and people had gained weight. The provider had implemented training to support staff to meet people's needs in a timely manner.

At our last inspection the provider had failed to ensure there were always enough staff on duty to ensure people received timely care. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

Staffing and recruitment
● The provider and registered manager had not always ensured staff were deployed effectively to meet people's needs.
● The provider did use a tool to assess the numbers of staff required. However, this did not explore potential issues such as the size and layout of the building, that care records were completed on a system that took time to complete or that evening and weekend staff spent much of their time answering the phone or the door. No adjustments to staffing levels had been made when the nurses medicine equipment was faulty and took much longer to use.
● 13 of the 21 relatives we spoke with told us they felt there were not enough staff on duty. Comments included, "I think they are short of staff, if you want to find someone to help you can't because they are all so busy." A different relative said, "The call bells take a long time to answer." Another relative said, "They are quite short of staff, especially at weekends."
● All of the 18-care staff and nurses we spoke with said there were not enough staff. Comments included, "People are not getting the care they need, we are losing staff and the home is so short staffed." A different staff member said, "Incidents happen because people are bored because there aren't enough staff on the dementia floor to spend time with people." Another staff member said, "We have staff members in tears because they don't have the time to give residents the basic care they deserve."
● Staff told us there was a high use of agency staff and this meant permanent staff had to spend time supporting the agency staff to use the providers systems and this left people waiting longer for care.

The provider had failed to ensure the staffing levels were adequate to meet people's needs safely using the systems in place. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately after the inspection we contacted the provider. They assured us that in response to our feedback they had arranged for there to be a supernumerary manager available on days and night shifts to support staff. They fixed the faulty medicines equipment and reduced the number of electronic care records staff needed to complete to make the process easier.

Using medicines safely
● People received their medicines as prescribed.
● Staff received training in medicine administration and their competency was assessed. However, agency staff responsible for supporting people to take their medicines did not receive training in the use of the providers medicine recording system. This meant there were times when errors were made that needed to be corrected by the permanent staff when they arrived on shift.

Systems and processes to safeguard people from the risk of abuse

● The registered manager had failed to ensure safeguarding referrals were made for the people who suffered from sore and broken skin.

● The provider and registered manager did work with safeguarding professionals and did make other referrals as necessary.

● Permanent staff completed training in safeguarding and were able to explain to us how to recognise potential signs of abuse. All staff told us they would feel confident to raise concerns of abuse with external professionals.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.'

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 supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● 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.

● There were no restrictions to people receiving visitors. People chose when and where they spent time with their visitors.

Inadequate

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 requires improvement. 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

- The provider had not ensured that quality performance, risks and regulatory requirements were always met. This left people at risk of harm. They had not always worked in line with their policies.
- The registered manager did not know who in the home was suffering with sore or broken skin or who was at risk of weight loss. This means they were not able to identify risks to people's health and wellbeing.
- Governance systems were not always operated effectively. For example, a monthly clinical governance audit had failed to answer required questions about people suffering with sore and broken skin, infections, accidents, incidents and falls. This meant there had not been consideration of identifying trends or how to prevent these happening in future.
- Daily flash meetings were held, the provider told us this would be where immediate risks to people were discussed and plans agreed to support people effectively. At the flash meeting held during the inspection, the team present failed to discuss the people with sore and broken skin or the person who had lost a significant amount of weight in a short period of time.
- During the first evening inspection, the registered manager was on call for emergencies in the home. The staff on duty used the on-call system but no-one responded to them. This meant there was a risk that staff would not receive support in emergency situations such as a staffing crisis or fire.
- When agency staff were employed, the registered manager had failed to assure themselves the agency staff had the required training to meet people's needs. One agency staff member had not completed basic training such as safeguarding and infection prevention and control.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- Staff did not feel listened to, valued or respected. The provider had failed to engage with staff effectively, or carry out a root cause analysis into why staff continued to feel staffing levels were too low.
- Many of the staff we spoke with told us they had been raising concerns of unsafe care with the registered manager for some time and felt their concerns were dismissed. One staff member said, "[Registered manager] does not do anything about the concerns we raise." A different staff member said, "We are not supported by the managers at all." Another staff member said, "The manager knows we are understaffed but does nothing about it."
- The provider had recognised that the recording system they used was no longer always effective, they were in the process of exploring new systems. However, they had failed to mitigate the risk of continuing to use the same system in the meantime. For example, the recording system was secured to walls in corridors,

when staff needed to record care entries they had to stay at the site on the corridor. We observed it took a staff member 23 minutes to input the care records for the last 2 and a half hours of their shift. Throughout this time, they were not able to support people with care.
● Staff told us there was a blame culture. One staff member said, "Lots of staff are leaving because management don't care." A different staff member said, "The managers say care staff are the problem but then won't work with us."

The provider had failed to ensure the governance processes were used effectively to assess and monitor the safety of the care provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately after the inspection we contacted the provider. They responded to the concerns we raised by increasing the management support within the home and instructing a clinical auditor to review records on a weekly basis. When we revisited the home a week later we found the assurances they gave us were in place and people's care had improved.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were not always achieving good outcomes from their care. The provider had failed to recognise the risks to people discussed in the safe section of this report.
● Some relatives told us they did not feel there was good communication with them when something happened with their relation. One relative said, "Communication about care is poor." A different relative said, "I wish they would keep us better informed; we always have to ask."
● Other relatives did speak highly of the management team and all relatives we spoke with praised the staff for being kind, caring and dedicated.
● Staff did not feel satisfied or respected in their roles and there was a recent high staff turnover.

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; Working in partnership with others
● The registered manager had not always met the duty of candour. They had failed to inform people and relatives of failings in care that led to sore and broken skin. However, as soon as the provider became aware during this inspection, they ensured the duty of candour was met.
● External professionals such as commissioners and healthcare professionals were engaged with effectively.

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 The provider had failed to ensure the staffing levels were adequate to meet people's needs safely using the systems in place.

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	Systems were not used effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm.

The enforcement action we took:

NoP to cancel 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	The provider had failed to ensure the governance processes were used effectively to assess and monitor the safety of the care provided.

The enforcement action we took:

NoP to cancel RM