Hill Care 1 Limited

Halton View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Halton View Care Home provides accommodation for persons who require personal care. The home provides support to older people including those living with dementia and can accommodate up to 64 people. The ground floor provides accommodation for people who require general residential care and the first floor accommodates people who are living with dementia. At the time of our inspection there were 52 people living at the home.

People's experience of using this service and what we found
There were ineffective processes in place to protect people from abuse or improper treatment. This exposed people living at the home to a risk of harm. Safety related themes and trends were not analysed reliably or robustly and there was little evidence of learning from events or action taken to improve safety.

People were exposed to a risk of harm as their care needs and associated risks had not been routinely assessed, monitored and mitigated and medicines were not managed safely.

Ineffective governance and quality assurance measures meant that people were exposed to unnecessary risk. Monitoring systems failed to identify all shortfalls found during the inspection in relation to risk management and mitigation, accident and incident analysis and governance.

The provider failed to share information with external organisations and professionals. For example, reportable incidents were not shared with the safeguarding authority and multiple statutory notifications were not submitted to the CQC.

There were enough staff to meet people's needs. However, staff were not always deployed effectively to ensure people's safety. We made a recommendation about this.

We saw that complaints were investigated and responded to. However, information was not always made available to a complainant about what further action they could take if they were not satisfied with how the provider responded to their complaint. We made a recommendation about this.

Staff followed good infection control practices and used personal protective equipment (PPE) to help prevent the spread of healthcare related infections. We observed friends and relatives visiting their loved ones during the inspection.

Staff supported people to stay in contact with those important to them. Relatives told us that staff had gone above and beyond to ensure contact was maintained with their loved ones throughout the COVID-19 pandemic. People and relatives provided many positive examples of how the home supported them in a person-centred way and described how they achieved good outcomes as a result.

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.

There were systems in place to obtain feedback from people, their relatives, staff and other stakeholders about the running of the service. The feedback was used to identify improvements. People were encouraged to be involved in the running of the home.

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

Rating at last inspection
The last rating for this service was good (published 23 September 2020).

Why we inspected
We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

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.

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 good to requires improvement based on the findings of this inspection.

The provider has been receptive to the concerns and taken immediate action to reduce the risk to people living at the home.

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 Halton View 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 and will take further action if needed.

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

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Halton View 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
The inspection was carried out by one adult social care inspector and one medicines inspector.

Service and service type
Halton view 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. Halton view Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. However, the current manager had submitted a registration application to the CQC in a timely manner.

Notice of inspection
The first day of the inspection was unannounced. We gave a short period of notice ahead of the second day of the inspection as we needed to be sure that the provider would be available to support the inspection.

Inspection activity started on 27 July 2022 and ended on 23 August 2022. We visited the home on 27 July 2022 and 3 August 2022.

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. 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 information gathered as part of monitoring activity that took place on 21 April 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 15 members of staff including the manager, regional manager, deputy manager, senior care staff, care staff and the person responsible for maintenance. We spoke with five people and four relatives about their experiences of care their loved ones received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records including five people's care records, multiple medication administration records, and two staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

We reviewed evidence that was sent to us remotely as well as seeking clarification from the provider and manager to validate evidence found. We looked at audit and governance data, as well as policies and procedures. We also informed commissioners and the local authority safeguarding team of the areas of risk we identified.

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

Systems and processes to safeguard people from the risk of abuse

- There were ineffective processes in place to protect people from abuse or improper treatment. This exposed people living at the home to a risk of harm.
- Multiple safeguarding incidents had occurred, and the provider had failed to investigate, take follow up action or share the concerns with the safeguarding authority. This meant people were exposed to further risk of harm because of a lack of action to protect them. We shared our concerns with the local authority safeguarding team.

The failure to operate effective systems to protect people from abuse or improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately and outlined the action they were taking to improve safeguarding systems and practice and provided assurances that all safeguarding issues would be shared with the safeguarding team.

Learning lessons when things go wrong

- Accident and incident processes were inadequate.
- Safety related themes and trends were not analysed reliably or robustly and there was little evidence of learning from events or action taken to improve safety. This resulted in repeat incidents occurring.

The lack of effective systems to identify and monitor risk and do all that is reasonably practicable to reduce the likelihood of harm was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider took steps to improve accidents and incident recording and analysis and took action to reduce the risk of harm to people living at the home.

Assessing risk, safety monitoring and management

- People were exposed to a risk of harm as their care needs and associated risks had not been routinely assessed, monitored and mitigated.
- Risk assessments were either not reflective of people's current needs or detailed enough to guide staff on safely supporting people. For example, the risk assessment for one person who had experienced multiple falls contained insufficient control measures to keep the person safe and reduce their risk of further falls.
- Incident records showed that one person had been involved in several physical altercations with other people living at the home. This level of risk was not reflected in the person's care records. This meant there

was insufficient information to guide staff on how to keep people safe from a known risk of harm.

The failure to robustly assess risks relating to the health, safety and welfare of people was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to the concerns we shared and took steps to update care plans to ensure they reflected people's current needs and risks.

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.

Using medicines safely
● Medicines were not managed safely.
● Information for medicines that were given 'as and when required' was not always available. This meant that staff did not always have instructions on how or when people should have their medicines.
● People's allergy information was not always recorded. There was a risk people could be given medicines that they were allergic to.
● Although staff were trained to administer medicines, not all staff had an up to date check of their competency to administer medicines to ensure they were able to do so safely.

The failure to ensure the safe management of medicines was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to the concerns and action was taken to improve the safe management of medicines.

Staffing and recruitment
● There were enough staff to meet people's needs. However, staff were not always deployed effectively to ensure effective monitoring of people during periods of emotional distress and this compromised people's safety.

We recommend the provider reviews staff planning and deployment to ensure people receive safe and effective care and support in a timely manner.

● Staff were safely recruited
● People and relatives told us that staff were competent and had the necessary skills to perform their roles safely. However, training records showed that many staff had overdue mandatory training courses. The

provider had already identified this, and an action plan was in place to address this.

Preventing and controlling infection

● Cleaners were on site throughout the day and worked hard to maintain a clean environment.

● Staff followed good infection control practices and used personal protective equipment (PPE) to help prevent the spread of healthcare related infections.

● We observed friends and relatives visiting their loved ones during the inspection. Relatives told us that there were no restrictions on visiting.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- There was a complaints management policy in place.
- We saw that complaints were investigated and responded to. However, within written correspondence, information was not always made available to a complainant about how to take action if they were not satisfied with how the provider responded to their complaint and did not reference other bodies the complaint could be escalated to.

We recommend the provider reviews their complaints management process to ensure information is provided to complainants about the routes of escalation available to them if they are not satisfied with the complaint response.

- Relatives and people told us they felt confident concerns would be addressed by the manager

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

- Not all care plans were sufficiently detailed to guide staff on people's current care, treatment and support needs. People were therefore at risk because staff did not have the most up to date information required to meet their needs. For example, when people experienced periods of emotional distress, they did not have effective plans to guide staff on reducing distress and keeping people safe.
- People and relatives provided many positive examples of how the home supported them in a person-centred way and described how they achieved good outcomes as a result. For example, one relative told us how staff had worked hard to ensure their loved one could transition from their respite stay back to their own home. This included ensuring they could safely administer their own medicines and independently prepare their own food and drinks.
- People and relatives confirmed that they could speak to the manager if they had anything they wanted to change about their support, and they were confident they would be listened to and their views respected.

Meeting people's communication needs

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

- People's communication needs were considered during the initial stages of the care planning process. This meant the manager could identify if information needed to be developed in accessible formats.

● People's care plans contained some details for staff to help them communicate with them effectively and included information about sensory aids such as glasses and hearing aids.

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

● Staff supported people to stay in contact with those important to them.

● Relatives told us that staff had gone above and beyond to ensure contact was maintained with their loved ones throughout the COVID-19 pandemic. One relative told us how staff used their own mobile phones for video calling. The relative described how their loved one's memory had declined in the period and they strongly felt their loved one only recognised them now because of the regular video calls.

● Our observations found that friendships had formed in the home and we observed people gathering in the lounge and talking over a coffee and cake. One relative told us, "It has been life changing for [person], the engagement with other residents has been really positive for her, the level of engagement and the support and care has made such a difference to her."

● We saw many examples of activities that had been enjoyed by people living at the home. People spoke positively about the activities co-ordinator. One person told us, "[Staff member] works really hard at arranging activities."

End of life care and support

● At the time of our inspection, no one using the service required end of life support. However, the provider understood that people's health could deteriorate and provided training for staff in this area.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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

- Ineffective governance and quality assurance measures meant that people were exposed to unnecessary risk. The provider was not robustly assessing, monitoring or mitigating risk relating to the health, safety and well-being of the people living at the home.
- Monitoring systems failed to identify all shortfalls found during the inspection process with risk management and mitigation, accident and incident analysis and governance. This meant opportunities to drive improvements to quality and safety were missed.
- Reporting of incidents, risks, issues and concerns was unreliable and inconsistent. The manager had ineffective oversight of all safety related incidents that had occurred in the home.
- Safeguarding incidents did not have the right level of scrutiny and oversight. The provider and the manager failed to follow their safeguarding policy as multiple safeguarding incidents had not been reported for investigation.

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

- The provider and manager were receptive to the concerns found during the inspection and took immediate and robust action to reduce the risk of harm to people living at the home and protect them from abuse. We were assured that enough action had been taken to mitigate risk and reduce the likelihood of harm before the inspection process concluded. Following the inspection, the provider submitted an action plan to demonstrate their ongoing commitment to improving the quality and safety of the service.

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; Working in partnership with others

- Due to gaps found with accident and incident recording, we were not assured that all relevant people had been notified of safety related incidents in a timely manner.
- The provider failed to share information with external organisations and professionals. For example, reportable incidents were not shared with the safeguarding authority and multiple statutory notifications were not submitted to the CQC.

● The provider did not always promote the provision of high-quality, person-centred care which fully protected people's human rights.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● There were systems in place to obtain feedback from people, their relatives, staff and other stakeholders about the running of the service. The feedback was used to identify improvements.
● People were encouraged to be involved in the running of the home. We saw examples where people contributed to the design and decoration of the premises. One person told us how they were involved in gardening and felt proud of their role in improving the look of the garden.
● The manager told us that one person who had recently stayed for a period of respite would be returning to the home and volunteering as a counsellor which was their former profession.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective systems to identify and monitor risk and there was a failure to do all that is reasonably practicable to reduce the likelihood of harm. The provider failed to robustly assess risks relating to the health, safety and welfare of people. The provider failed to ensure the safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate effective systems to protect people from abuse or improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were effective governance and quality assurance measures in place to drive the necessary improvements to quality and safety.