

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?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This comprehensive inspection took place on the 22, 23 January and 13 March 2018. The first and third days were unannounced, the second was announced.

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 building comprising of 64 single bedrooms located within three separate units, all having en-suite toilet and shower facilities. There is a range of communal spaces including lounges, dining and sitting areas. Toilet and bathroom facilities are dispersed throughout the building.

At the time of the inspection there were 62 people living at Halton View. The accommodation was split into a residential unit on the ground floor and male and mixed units accommodating people living with dementia on the first floor. There were twenty eight people living in the residential unit, 23 living in the mixed unit and 13 living in the male unit.

The service did not have a registered manager in post. 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. Previous registered managers had not completed the process of de-registration however were no longer employed by the service. A new home manager had recently been appointed but had yet to begin their application to become the next registered manager.

We identified three breaches of relevant legislation, in respect of safe care and treatment, staffing and governance.

Overall people and relatives we spoke with were positive about the care and support they received at Halton View and spoke favourably about the staff. We observed many caring interactions although we saw one member of staff supporting a person whilst using their mobile phone. This was brought to the attention of the regional manager who advised they would address this with the staff member concerned.

We found that sufficient numbers of staff had not been deployed by the registered provider, particularly in one area of the home. This impacted upon the care that people received and the level of supervision and monitoring of support needs that staff were able to achieve. Although a dependency tool was used to determine staffing needs, we saw that this did not take into account the level of supervision that was needed and therefore, we queried the accuracy of the outcome.

We found shortfalls in the safe management of medicines. We saw that there were occasions when stocks had been allowed to run out or staff could not locate them, which meant that people did not receive their medicines as prescribed.

Although the home was visibly clean and tidy some areas were malodorous. This had improved on the final day of inspection but remained an issue. The service was working with the local infection prevention and control team to manage this issue who made a recommendation to install impermeable flooring had been made.

We saw that staff did not always follow guidance given by external professionals and risk assessments to mitigate risks, for example for a person who was at risk of choking.

The registered provider followed safe recruitment procedures to ensure that people employed were suitable to work with adults at risk of harm or abuse. Staff had received training and demonstrated an understanding of their responsibilities with regard to reporting abuse and whistle-blowing.

Arrangements were in place for checking the environment at Halton View to ensure it was a safe place for people to live. We spot checked safety certificates and found these were up to date.

People, visitors and staff felt that staff had received the training needed to deliver care that was effective. Communication, staff supervision, appraisal and meetings had improved since the appointment of the new manager.

We saw that the provider was working within the principles and requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were complimentary about the nutritious food which was available.

The provider had plans to improve the environment within Halton View with new furniture already having been purchased and further plans to improve soft furnishings and flooring. The hairdressing salon had been refurbished and café area improved.

Details of advocacy services were available for people who did not have family or friends to support them.

People told us that they were able to make choices such as what to eat and where to eat their meals. However, we identified that some restrictive practice had taken place with the removal of seating from the corridor of one unit.

Improvement was needed with regard to person centred care planning including involvement of the people living at Halton View and their representatives where appropriate. The manager had identified this as an area for improvement and had already begun measures to achieve the necessary improvement.

There had been a lack of meaningful activities following the departure of the activity co-ordinator. On the final day of inspection we saw that a new co-ordinator had been appointed.

There was a policy for monitoring and responding to complaints. People we spoke with were aware of how to make a complaint and who to speak with if they needed to.

The provider used a suite of audits to assess and monitor the quality of the service. However, we found that these were not sufficiently robust to have identified all of the concerns noted during this inspection.

During the inspection we found the manager and regional manager to be approachable and responsive to feedback. The manager's enthusiasm and drive to improve the service was evident. They had identified key

challenges and on the last day of inspection we saw that some improvement was evident.

You can see what action we told the provider to take at the back of the full version of the report.

## 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 consistently safe.

The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed.

Management and administration of medicines was not always safe.

Care and treatment was not always provided in a safe way.

Staff had an understanding and were aware of their responsibilities with regard to protecting people at risk of harm from abuse.

Safe recruitment procedures were in place to ensure that suitable people were employed.

### Is the service effective?

**Good** 

The service was effective.

Staff had received the training they needed to carry out their role effectively.

The provider was complying with the principles of the Mental Capacity Act 2005 and requirements of the Deprivation of Liberty Safeguards.

People told us that the food was of a good standard and we saw that it was nutritious.

We saw that improvements had been made in some areas of the environment.

### Is the service caring?

**Good** 

The service was caring.

People spoke positively about the care they received.

We observed staff to care for people in a kind and caring way.

The provider supported people to maintain relationships.

Information about advocacy services was made available for people who do not have family or friends to represent them.

People were supported to be as independent as they could be.

### **Is the service responsive?**

The service was not always responsive.

People were not always involved in developing or reviewing their plan of care.

We saw that people's choice was not always respected.

Although some improvements had been made to the quality of care plans, further improvement was still required

People were supported to maintain their independence as far as they were available.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

The service did not have a registered manager in post.

Quality assurance systems were not sufficiently robust to have identified all of the concerns noted during this inspection.

Staff morale had improved with the appointment of the new manager.

**Requires Improvement** ●

# Halton View Care Home

## Detailed findings

### Background to this inspection

This comprehensive inspection was carried out on 22, 23 January and 13 March 2018. The first and third days of inspection were unannounced, the second announced. The inspection was carried out by two adult social care inspectors, a specialist advisor and two experts by experience on the first day, one adult social care inspector a specialist advisor and two experts by experience on the second day and one adult social care inspector on the third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a registered nurse.

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.

Before the inspection we contacted the local authority quality assurance and safeguarding teams and they were shared their current knowledge about the home which was used to help plan the inspection. Following the inspection we contacted two external professionals who visit the service.

We also looked at information we held about the service. This included notifications we had received from the registered provider about incidents that affected the health, safety and welfare of people who lived at the home, previous inspection reports and concerns raised by staff and members of the public. We had received some whistleblowing concerns which we shared with and were investigated by the local authority safeguarding team. A visit by the local authority identified concerns with regard to staffing levels on the male unit and, as a result staffing levels were increased.

We checked whether a Health Watch visit had taken place and saw that the last visit was in November 2016. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. The report they produced gave a positive view from their visit.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with 20 people who lived at the home, 12 visitors, seven care staff,

the chef, kitchen assistant, manager and regional manager. We also reviewed documentation which included three personnel files, six care files and other documentation related to the running of the home.



# Is the service safe?

## Our findings

Most of the people we spoke with said that they felt safe living at Halton View and that they knew who to speak with if they did not feel safe. Their replies included "Very much so, I love it"; "Yes, the officer in charge, it's like a family here, we are very happy here"; "The home is smashing, all right for me" and "Definitely safe." However, one person said that they did not feel safe as other people entered their room at night.

Prior to the inspection we had received some whistleblowing concerns about staffing levels on the male unit. A visiting professional we spoke with on the first day of inspection said they had concerns about staffing levels as they found it difficult to locate staff to support them during their visits.

Staffing levels on the first day of inspection were one senior care assistant plus three care assistants on the residential unit, three care assistants on the mixed and male dementia units with one senior care assistant covering both units. We saw that allocation of senior care assistant/unit manager varied as on the last day of inspection there was a senior care assistant allocated to each of the dementia units.

On each day of the inspection, we observed on several occasions a person living with dementia entering other people's rooms. We saw that one person was visibly upset by this and they told us that this happened regularly as (Name) was "constantly coming in day and night" and that this had happened four times already that day. On a number of the occasions we observed there were no staff in the vicinity. Therefore staff were unaware of how frequently this was happening and were not on hand to deal with subsequent distress. Another person told us that they did not feel safe as people were always entering their room at night, as noted above.

The person's care plan included several references that their movements should be monitored and supervised at all times including 'when (Name) is with others'. We saw that this level of supervision was not taking place and would not be possible with the staffing levels on that unit. We also observed that a person on the mixed unit had been served their breakfast in their room. The food was untouched and cold however staff were busy supporting other people.

On the first day of the inspection we asked about occupancy and staffing levels including on the upstairs units which support people living with dementia. We were told that there were 13 people living on the male unit and 23 on the mixed unit. We were informed that there was three care staff on the male unit, three care staff on the mixed unit with one senior care assistant covering both units. We raised concerns with the manager and registered manager regarding the level of staff support on the mixed and male units, caring for people living with dementia, versus the difference in occupancy and how this would impact on the care which staff were able to deliver.

The registered provider used a dependency tool to determine staffing levels and we were shown examples specific to each unit of the home. The tool identified whether people were low, medium or highly dependent and these figures were used to determine the number of care hours required. However, we saw that the dependency tool did not take into account the level of supervision people needed which would impact upon staffing requirements. The person noted as requiring constant supervision was assessed as low

dependency. Therefore, we would question the accuracy of the staffing needs outcome when assessment results were linked to the staffing tool which was corroborated by our direct observations during the inspection.

We asked people living at Halton View if they felt there was sufficient staff to meet their needs. The majority of people we spoke with felt there was not always sufficient staff. Their comments included "Not enough of them- have to cover two floors": "Overall no": "No presence in the lounge": "Sometimes yes and sometimes no": "No have to wait for the toilet" and "No, I don't think so". Others said "Always enough staff."

Visitors told us "Sometimes a little short staffed"; "Run off their feet"; "Staff are really lovely people but there is not enough hours in the day that's why things don't get done"; one person said that there seemed to be enough whilst another felt that there seemed to be fewer staff in the evenings.

Although there was some variation in staff comments with regard to staffing levels, which may have been due to unit they worked on, the majority spoken with felt there were not enough staff. Some felt there were enough staff and they did not have to rush, others felt there was insufficient staff to meet people's needs particularly on the mixed unit. Comments included "Very busy on the mixed unit"; "Can't understand why it drops in an afternoon"; "Staff overworking to get basics done"; "Still need more staff, still doing paperwork at 11.50"; "Tough to catch up when drops to three, when there is four we can manage" and "Need four carers all day."

We asked staff how the issues they described would impact on the people living at Halton View and were told, "People have to wait longer for the toilet, staff need to rush and supervision suffers because of two attending to one person"; "No time for them, it's like a conveyer belt when you come in a morning. That's all it is personal care, meals, personal care, meals and it's not fair on them"; "Longer waits for toileting" "People get left in wheelchairs because there is not enough time" and "One lady can't go out for a cigarette when there are only three (staff)."

One staff member explained they, "Have to get up to 11 people ready for bed before night staff come in" and that this impacted on people's choice for going to bed. Sometimes can only do pad change." This comment again related to the mixed unit.

On the mixed unit we were told that there were four care staff until 2pm when numbers dropped to three care staff. Although there would be a senior health care assistant on duty we were told they may be busy with medication, other jobs or covering two units. The majority of staff spoken with felt this placed a significant strain on staff which impacted upon the level and quality of care delivered.

During the inspection there were times when it was difficult to locate staff. We also saw that carers had to leave tasks or people they were supporting. For example, we saw that a carer supporting a person with their meal had to leave the dining room to respond to a call bell and another who was serving afternoon drinks had to stop to support a person with continence needs.

Staff told us that they had raised concerns with management about staffing levels but that it was "Like talking to a brick wall – that's the ratio." We were concerned about staffing levels particularly on the mixed unit and raised this matter with both the manager and regional manager, including whether the dependency tool gave an accurate assessment if level if supervision needs were not taken into account.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the procedures for management and administration of medicines were not always safe and that the policies in place were not always adhered to.

We saw that medication administration records (MAR) were not always completed as required. For example, we found that handwritten MARs had not been signed by staff as required and that there were numerous instances of missing signatures. Where signatures were missing there was no evidence of follow up to determine whether this related to an error in recording or to a missed dose of medicine.

Records reviewed indicated that some people did not receive their medicines or topical applications as prescribed due to stocks running out or staff being unable to locate them. Examples included, 1 to 3 January 2018 "awaiting stock"; 1 and 2 January 2018 "no stock"; 10 to 16 January 2018 "no stock", this had also been recorded on the back of the wrong MAR; 2 January 2018 "no stock" and 11 January 2018 "Couldn't locate"; 9 January 2018 "Couldn't locate" and "4 to 21 January "No Medihoney".

One medicine was administered by transdermal patch (a patch applied to the skin) and records noted that staff should check daily to ensure that the patch was in place –we saw from records for one person that there was no evidence checks had been made on 7, 8, 11,12,13,14 and 15 January 2018 and for another for 21 and 22 January 2018.

Some medicines need to be stored within specific temperature ranges. Monitoring of these temperatures is important because some medicines can be damaged by storage at excessive temperatures. We saw that the process to check temperatures remained within the acceptable range was not sufficiently robust and that checks were not always made as required.

Protocols were in place for administration of medicines that were prescribed to be taken pro re nata (PRN)(when required) although we found that these did not always contain sufficient detail to ensure a consistent approach when administering 'as required' medicines. For example, a staff member was knowledgeable about a person's pain management however the level of detail they described to us was not included in the relevant protocol so that all staff would be aware of this information. The effect of PRN medicines was not always recorded to monitor whether it was addressing the symptoms for which it was prescribed.

Medicines were stored in locked trolleys which were kept in a medicines room when not in use. We observed that a staff member had left a medicines trolley in the entrance area whilst they were carrying out their medication round but it was not secured to the wall. We saw that one of the medicine rooms was very small and that staff had no room to move when the trolleys were stored there.

Controlled drugs were securely stored and recorded as required. Controlled drugs are prescription medicines that have controls in place under the Misuse of drugs Act and associated legislation. We observed staff administering medicines and saw that they followed the correct procedures for administration and stocks sampled were correct. Whilst administering medicines the member of staff wore a red tabard to note that they should not be disturbed whilst in order to reduce the potential for administration errors.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

The provider had policies relating to the safe management and administration of medicines in place, staff received training and there was a process in place to review the competency of staff responsible for

administering medicines. People told us that they received their medicines when they needed, although not all were aware of what they were for.

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Some people required a prescribed powder to thicken their fluids to reduce the risk of aspiration or choking. We saw that information recorded on a chart accompanying the drinks trolley contained conflicting/inaccurate information with regard to the amount of scoops needed for the stage of thickening required. This also conflicted with the guidance noted on the chart. For example, one person was noted as requiring 'custard' consistency fluids with two scoops of powder. The guidance on the form noted that for custard consistency three scoops were required per 200mls of fluid.

We reviewed this person's care plan and saw that they were at risk of choking and had been assessed by the Speech and Language Team (SALT) on 2 January 2018 following a choking incident. SALT guidance on file noted prescribed techniques to mitigate risks which included "No straws to be used with fluids" however, the risk assessment in place had not been updated to reflect this instruction. We then observed a staff member supporting the person to drink using a straw. The member of staff told us that they were aware that (Name) should not use a straw but that they were "proud and wanted to be independent." This action left the person at increased risk of choking. We made the manager aware of this observation and they immediately carried out supervision with staff in this regard in addition to reviewing requirements with SALT.

During the first and second day of inspection we saw that some people had pressure mats in situ. These were used for people at risk of falls to alert staff when they mobilised. We saw that several would not have been effective due where they had been positioned, for example to the side of the chairs and under the bed. We brought this to the attention of a member of staff who repositioned a mat but once again placed it where it would not be effective. We also saw that the mats easily slipped on the carpet as they did not have non-slip covers creating an increased risk of falls. We discussed this information with the manager and on the last day of inspection saw that mats were appropriately placed however non-slip protectors were still not in use leaving people at risk.

During the first day of inspection the visiting district nurse team and a member of the inspection team raised concern about the care provided to a person who had a urinary catheter in situ. This person was subsequently admitted to hospital and a safeguarding referral was raised in this regard which was substantiated. Concerns were also raised about the accuracy of fluid intake charts. Following the outcome of the safeguarding investigation we saw that the manager had provided feedback to staff to identify "where did we go wrong" to ensure continued improvement.

We saw that care plans and risk assessments had not always been implemented leaving people at risk of unsafe or improper care and treatment. For example, the care file for a person who had been at Halton View for a period of approximately 13 days did not contain any care plans or risk assessments to provide guidance to staff about their needs. Information received from family and in daily notes indicated that the person was diabetic and required wound dressings to be applied. Their dietary needs had not been added to the kitchen menus and we observed that staff had offered the person biscuits which were not suitable for diabetic diet.

Other care plans did not contain sufficient detail and required further development. On the last day of inspection the manager informed us that they had introduced a senior carer programme which involved meeting with staff to provide individual guidance to improve quality. The current focus was on care plans and the manager had worked with staff to help them develop care planning skills. Although further work was ongoing, files reviewed during that visit demonstrated an improvement in standards and plans were in place to improve all care plans.

These issues were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

Upon arrival on the first day of inspection we found that there was a significant malodour of urine in the entrance and downstairs lounge area. We were informed that this was due to a spillage and measures were taken to address this issue. On the second and third days of inspection improvement was noted however a malodour was still evident. The lounge in one of the upstairs units was also malodourous.

Following the inspection we contacted the local infection prevention and control team. They told us that they had seen recent improvements with regard to infection control measures within Halton View and that they were working with the service. They had made a recommendation that carpets were replaced with impermeable flooring to address the malodour issues. During the inspection the home appeared visibly clean and tidy. People told us "It's always been nice and clean" and "It's clean and tidy and that's what you want". Staff made appropriate use of personal protective equipment (PPE) to reduce the risk of infection.

We looked at three staff files to review recruitment practices that were in place and found them to be safe. We reviewed the area of 'recruitment' to ensure that staff who were recruited were suitable to work with vulnerable people. Records included application forms, interview records, references, identification and Disclosure and Barring Service (DBS) checks. DBS checks are used by employers to establish if recruits have a criminal record or are barred from working with vulnerable adults or children. This helps employers to make safer recruitment choices.

We saw that when agency staff were used the provider made checks with the agency to ensure these staff had received appropriate training and DBS checks undertaken and that agency staff received an induction. The manager had actively increased recruitment in an effort to reduce the use of agency staff and a deputy manager role had been introduced.

Safeguarding and 'whistleblowing' procedures were discussed with staff and those spoken with were aware of the policies and procedures in place. They were able to explain their understanding of safeguarding and whistleblowing and received the necessary training in relation to the protection of adults at risk of harm. When asked if they would feel able to whistle-blow or report abuse we were told "Yes, in a heartbeat." Since their arrival the manager had linked with the local authority safeguarding team with regard to safeguarding incidents and we saw that these were investigated, disciplinary procedures implemented where necessary and learning points considered.

The manager had suitable accident and incident processes in place. Accidents and incidents were recorded on a reporting form and staff were aware of the process to follow should an accident occur. Reporting forms included information about time, location, type of injury and outcome. Analysis of all accidents which occurred in 2017 had taken place to support an overview to identify themes and trends. There was also a monthly overview which included the number of falls for each person. We recommended the manager considered analysis per unit in addition to their overall analysis.

We saw risk assessments were completed for risks such as falls, malnutrition and pressure damage. We saw where a person was assessed as being at high risk of pressure damage a detailed care plan was in place giving staff clear guidance to follow 'React to Red' guidance which includes specific instruction for pressure sore prevention.

Regular environment and equipment safety checks were carried out which included fire, water, gas and electrical installation. Confidential records were securely stored however, we observed the door to the senior's office in the entrance area was left open when not occupied leaving access to people's care files. We discussed with the manager and they confirmed that they would review this situation.

On several occasions we saw a rear exit fire door had been propped open by staff using the smoking shelter which posed an increased fire and security risk. We also found that bags of rubbish had been left close to the bin for discarded cigarettes. We brought this to the attention of the manager who took action to remove the rubbish. On the last day of inspection we did not see the door left open.

## Is the service effective?

### Our findings

People and relatives we spoke with said they thought the staff supporting them had the skills and knowledge to effectively meet their needs. Comments included, "Of course they do, they look after my needs"; "From what I've seen it's fine"; "Happy here and looked after"; "I think it's fantastic" and "Staff know residents well."

Staff expressed that they felt they had received the training they required to carry out their roles effectively and that additional training would be made available if they felt it was needed. Staff we spoke with said they felt supported in their role and when asked how they were supported said, "knowing there is someone you can turn to" and that they had received supervision and annual appraisal. New staff received an induction. Two staff we spoke with explained they had undertaken training and completed a three day induction. Another had changed role and said they did not have a specific induction but that they had received clear expectations and guidance from management and were enjoying their new role.

We saw that staff meetings were now taking place and staff felt they were worthwhile. Dates had been scheduled for meetings throughout 2018 and minutes were available for the meeting which had taken place in February 2018.

Communication systems were reviewed during the inspection and we found there were different levels of communication in place. There was a handover for each shift and daily records were updated as required. Staff, daily head of department and relative/resident meetings took place as did staff supervision and appraisal. We saw supervision was carried out on a 1:1 basis and in group sessions, topics recently covered included management, falls risk assessments, thickeners, developing senior carer skills and allocations. We saw information was displayed on notice boards which included details of advocacy services, stroke and Stroke Association, falls, complaints and protected meal times.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. We saw that policies and procedures were in place and discussed the requirements of the MCA the management team. Detailed records were maintained to ensure ongoing compliance. Staff we spoke with were able to demonstrate an understanding and working knowledge of MCA and DoLS, although one fairly new member of staff was unsure of the meaning of these terms.

Although evidence of consent to care plans was seen we found that this needed to be improved as some



documentation had not been signed for to evidence that people, or their representatives, had consented to their plan of care. The manager was aware of this and explained that addressing such issues would form part of the review and improvement of care plans which was underway in order to deliver effective outcomes and clearly evidence consent.

The service had implemented protected mealtimes, this was to promote privacy and protect people's dignity. Each unit had its own dining area and facilities were available for visitors to have meals with their relative in the café areas. The café area was also available for people who preferred a quieter environment and this had effectively improved one person's dietary intake as they found it less distracting. We saw that staff supported people who needed help with their meals in a dignified manner, sitting beside people and offering encouragement where appropriate. However, we did see that one staff member had to leave to carry out another task whilst they were supporting someone with their meal.

Almost all people spoken with were complimentary about the meals provided telling us that the food was good, enjoyable and that they had plenty to eat. Comments included "Meals are fabulous. Plenty, they do taste nice"; "Food is grand"; "Meals are fantastic" and "I am particular but I can't fault it." However, one person felt that the food was not hot enough, the meat was not lean and there were not enough fresh vegetables.

During the inspection we observed meal service on all units and sampled the food served which we found to be tasty and nutritious. We saw that alternatives were offered to people who were not eating what was originally served. On an upstairs unit we saw that portions served were large and that there was a significant amount of waste. We also saw that food had been plated for people who were asleep and left on the side to eat later however they were left uncovered which demonstrated poor food hygiene standards.

People told us that they had choice about where to eat their meals. Most people felt there was sufficient choice although one person did not. We observed a staff member asking what people would like to eat for their meals that day with three choices offered. Tea and biscuits were served morning and afternoon and we saw drinks were readily available throughout the day; with one person telling us "I can get a drink when I want to." A rotation system was used for menus and those we reviewed evidence that there was always an alternative option offered.

The manager told us of their plans to ensure continuous improvement with regard to nutrition and diet with a "healthy wellbeing plate", special diet alternatives, options and fortified diet. On the first day of inspection we found that the kitchen staff were not aware of people's food allergies that were detailed within care records. For example, one person was noted to be allergic to shrimp and another to tuna. On the third day of inspection we found that this had been addressed and that allergies were clearly noted.

The risk of malnutrition was assessed using a MUST (Malnutrition Universal Screening Tool). The manager told us that additional training had been provided and that she had worked with staff with regard to the use of this tool to ensure it was completed accurately and effectively. They felt improvement was now evident and that staff felt comfortable to ask if they had any questions. Samples reviewed evidenced correct completion.

The manager was new in post and had been present for only a few days when the inspection began following a period of annual leave. On the third day of inspection, which was some weeks later, they were able to show us improvements they had made to the premises. An area near the smoking shelter had been cleared and new furniture purchased. This included new dining and lounge chairs with further plans to replace soft furnishings and consideration to replacement flooring.



The hairdressing salon had been refurbished, new decoration, shelving, flooring installed and new over-head dryers ordered. The hairdresser was present on the third day and we saw two ladies having their hair styled who were clearly enjoying the new facilities. A café area had been created on one of the upstairs units and the Greenwood Café on ground floor had been improved which was neatly set with tables and flowers. This had been used for afternoon tea on Mother's Day which was attended and enjoyed by ten families and 20 people living at the home.

Records maintained showed staff sought advice from the doctor and made requests for specialists when they believed this to be necessary in order to meet people's health needs. We saw people had access to their GP, district nurses and other specialists such as dentist, optician, SALT, chiropodist, podiatrist and dietician when this was required. We saw from records that the provider engaged with these services as and when needed.

## Is the service caring?

### Our findings

We received positive comments from the people and visitors we spoke with during the inspection about the care which was provided. People told us they felt staff were caring and respectful. They said "They are really lovely, otherwise I wouldn't be here", "(Relative) is here because of the people working here, they are amazing"; "Oh yeah, they are caring. They are here to help when you need help"; "The girls are like home from home, can't explain it" and "Kind, nothing is too much trouble for them."

Staff received regular updates in relation to the people's health and well-being. They were familiar with the needs of the people they were supporting.

During the inspection staff interactions were observed to be of a kind and caring nature, with staff showing warmth to the people living at Halton View. We saw that staff were respectful in manner, addressing people by name, knocking on doors before entering and supporting people discreetly to protect their privacy and dignity. We did, however, observe one member of staff using their mobile phone whilst assisting a person into a lounge which was disrespectful and inappropriate. We made the manager and regional manager aware of this observation who agreed it was not acceptable. They advised they would address this with the member of staff concerned.

People said that they felt listened to telling us "Oh yes, I must admit this is a fabulous place, the nurse and staff are very nice"; "I've got no problems in this place" and "Yes, very much so". When asked what they felt staff did well one person said "Everything."

Visitors told us that they were made to feel welcome by staff and that they had "good conversations with the staff." Comments included "Oh yes, as soon as I come through the doors the girls greet me" and "Last week when (Relative) wasn't feeling well, the girls called me to say (Relative) was OK as I was worried." One visitor told us their relative, "Loves it when staff given her a cuddle and put their arm around her." The manager was actively encouraging people to maintain relationships by creating a welcoming atmosphere for events such as the Mother's Day and St Patrick's Day celebrations in addition to improving the Greenwood Café area which could be used for family dining and other events.

We asked whether staff would be happy for a relative of theirs to receive care at Halton View. Views varied with comments including "I would now, my team are so caring and put those people's best interests first and foremost every single day"; "Yes, I think we provide good quality care"..". However, others said they would not be, their views linked to the concerns about staffing levels covered in the Safe section of this report. They said, "No, because there are not enough staff to meet needs, it's too rushed" and "No, because it's like being on a conveyer belt for them."

People were supported to be as independent as they could be. They told us, "I dress myself, wash myself" and "I do everything myself. A little nervous at first I'm now independent. They (staff) helped me to be confident."

For people who did not have any family or friends to represent them, information and contact details for advocacy services were clearly displayed within the home and made available to people using the service when appropriate.

During the inspection we reviewed how confidential information was stored and protected. We saw that facilities were available to ensure that information was stored safely and securely. We discussed with the manager that we had observed the senior office door on the ground floor being left open when staff were not present leaving personal files on view. They advised they would take appropriate action to address this matter.

The service had an equality and diversity policy in place to ensure that people were treated fairly and without discrimination. During the inspection we saw that people were treated fairly.

## Is the service responsive?

### Our findings

Most people and visitors we spoke with during the inspection told us that staff were responsive to people's needs. Comments included "The way they treat people, they talk to them like human beings and as individuals"; "Anything I want they will get it for me"; "If you need anything, if you are not well, they get you drinks and get you better" and "Staff know what (Relative) likes."

People told that they were able to make choices such as what to eat and where to eat their meals. There was a difference of opinion from people with regard to choice of when to get up or go to bed. Some said that they could choose whilst another said they had to go to bed when the staff said and got up when staff put the light on.

On the first and second day of inspection we saw that chairs were available in the corridor of the mixed unit and that people regularly stopped as they walked either to rest or to watch what was going on. However, on the final day of inspection this seating had been removed. A staff member told us that the chairs had been removed because "If chairs are there in the day they won't go in the lounge. If two chairs everyone wants to sit there." This was a clear restriction on people's choice and the action had taken away the facility for people to rest should they tire while walking. We saw one person who was struggling to find their room. We noticed that there were no names, photographs or memory boxes displayed to support orientation for people living with dementia. We would recommend that the provider reviews the environment on the upstairs units to ensure it is dementia friendly and responsive to people's needs.

On the first and second day of inspection we found that significant improvement was needed with regard to care planning. Although we saw that staff knew people well and were aware of their needs, we found that improvement was needed with regard to care plans to ensure that they were person centred, contained sufficient detail and were reflective of people's needs giving all staff the guidance they would need to provide appropriate care and support. For example, there was no real detail about managing a person's wandersome behaviour and some care plans had been written in 2016 which meant reading through numerous evaluations to understand their current needs. The manager told us they were aware that improvement was needed in this area and we saw that they had plans in place to achieve this.

On the third day of inspection we saw evidence that work had started to make the required improvements and that the standard of a newly written one reviewed was much improved. People's choices, likes and dislikes were better reflected as were health and care needs. For example, "I have a duvet and 2 pillows on my bed – before I go to bed I would like to use the toilet; I am a social lady, I like to have TV on in my room. Sits with (Name) in her room until time for supper then (Name) will go back to her room".

We asked if people had been involved in drawing up and reviewing their care plans. We found there was a lack of involvement of people using the service, or their representatives where appropriate. People and visitors were largely unaware or unsure if they had seen or been involved in the development of their plan of care. Comments included "No, not seen care plan" and "Didn't know I had one" and "Once I think." One person said they had seen their care plan and discussed it with staff whilst another said they knew about it

but had not had any input into it. The manager was aware of the need to improve involvement and this formed part of their programme for care plan review.

In order to support the required improvements, the manager had introduced a senior carer programme which involved regular individual meetings with staff to provide support and guidance. The initial focus of the programme had been on care planning with the manager supporting staff members to create a quality care plan. The next focus planned was to cover supporting external professionals during visits to the home.

At the start of the inspection activities within Halton View were provided by a volunteer following the departure of the previous activity co-ordinator. The manager told us that care staff had been given details of scheduled activities they should provide, however, staff we spoke with told us that they had been unable to support with activities as they did not have time. By the final day of inspection an activity co-ordinator had been employed and they demonstrated enthusiasm for their new role.

Regarding activities, people told us "They don't have any"; "Not seen much"; "Not a lot going on" and "Hit and miss lately" with one person saying "Terrible place, left in room, nothing happens." The activity co-ordinator told us they were settling into their role and that they had plans to improve activities. On the third day of inspection a knitting and sewing class was scheduled for the afternoon, they had organised the Mother's Day tea party and had introduced 1:1 sessions.

On the third day of inspection, we observed a person asleep on their bed looking unkempt and dishevelled. Staff were able to explain that the person had been extremely agitated and that this was the first time they had rested that morning, therefore they were monitoring whilst allowing a period of calm. Staff had contacted the GP to request a visit. Although the GP had declined this request, the provider was making strenuous efforts to ensure that this person was seen by health professionals and was liaising with a care home support team to facilitate this. We later saw that the person was calm, sitting up and comfortable.

The registered provider had a policy and procedure in place for monitoring and responding to complaints. The procedure for making a complaint was clear and people and relatives we spoke with were familiar with the process and knew who they would to speak with should the need arise. One person said "Any of them (staff), they will listen to me. There isn't much to complain about."

We asked the manager if 'end of life' care was being provided to people they were supporting. We were informed that there was nobody supported with 'end of life' care at the time of the inspection. One person was being regularly reviewed by the GP with anticipatory medicines prescribed to ensure that, should the person's condition deteriorate, measures were in place to meet their needs. The manager told us that staff had been enrolled on the next 'Six Steps' training which is a programme to support and improve care at end stages of life. The manager was knowledgeable about and keen to ensure high quality 'end of life' care was provided.

## Is the service well-led?

### Our findings

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There had been changes in management since our last inspection and, although two previous managers had not cancelled their registration, they were no longer employed by the provider. A new manager was in post and they were about to commence the process of applying to the CQC to be the next registered manager. At the start of the inspection they had been present in the home for only a few days due to a period of annual leave which was scheduled prior to their appointment.

Quality Assurance systems were not sufficiently robust to have identified all of the concerns noted during this inspection. Staff told us that they had previously raised concerns about staffing levels, a local authority visit had identified similar concerns and during the inspection we found that the provider had not deployed sufficient numbers of staff.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of regulated activities (including the quality of the experience of service users in receiving those services).

There was a suite of audits and observations used to ensure the quality of the service which were carried out by the home manager and regional manager. We saw that these included audits linked to each of the five key lines of enquiry inspected by the CQC, infection control, observational and medication. Although audits were detailed and included actions and timescales we saw that there was not always evidence of completion of those actions and that certain issues appeared on successive audits. We would recommend that the manager reviews the process for monitoring action requirements as part of their improvement plan to ensure that improvements made are maintained.

As of April 2015, providers were legally required to display their CQC rating. The ratings are designed to provide people who use services and the public, with a clear statement about the quality and safety of the care being provided. The ratings inform the public whether a service is outstanding, good, requires improvement or inadequate. On arrival we found that the rating was not displayed, however the manager took immediate steps to address this ensuring that it was displayed in the foyer.

During the inspection we found the manager and regional manager to be approachable and responsive to feedback provided. They engaged actively throughout providing all documentation that was requested. We received an improvement plan following the first two days of inspection and saw that actions noted had been addressed when we returned for the third day. The manager told us that they had been well supported by the regional manager. They also liaised with managers of the provider's other services within the region.

In addition they had attended a provider forum held by the local authority which allowed them to network with other local home managers.

We were told that staff morale had improved since the current manager had arrived and that staff felt supported by the management team. Comments included "(Name) seems approachable, seems to be in control, better than last manager"; "Has been really low, horrendous, has got better now" "I like (Name), I can say anything to her" and "Better than when (Name) was here, people are more relaxed and feel supported." Staff had been told by the manager, "I'm here if you need anything." Negative comments received from staff related to previous management as mentioned above and lack of staff which we have covered in the Safe section of this report. We were told by a staff member, "There are a lot of caring people working here, really passionate but too much is expected of them. Get disheartened because not enough time."

Staff told us that if they could change something about their job it would be more staff and a consistent manager. The management team were aware of the need to provide stability and this was a clear focus moving forward.

The manager's enthusiasm and drive to improve the service was evident. They had already identified key challenges and by the last day of inspection, although these areas were still a work in progress, we could see the benefit of changes that they had already implemented. These included care planning, staff development, culture, environmental, significant reduction in the use of agency staff and improved relationships with external professionals. New initiatives had been introduced such as, the senior carer programme and employee of the month and they were developing links with the community with plans for a local nursery to visit, church services and Holy Communion. The manager was aware that there were no people living at Halton View at present who held different religious beliefs, however, told us that arrangements would be implemented to support those beliefs should the need arise.

The manager operated an open door policy and questionnaires were distributed to enable people, relatives and staff to express their views.

The manager undertook regular observations of the service including mealtimes and carried out a daily walk round. They also planned to relocate their office to the entrance area so that they would have a more visible presence to visitors, staff and people using the service.

Services which provide health and social care to people are required to inform the CQC of important events that happen in the service. We were aware that the manager had identified we had not been informed of some incidents by the previous manager and therefore did so retrospectively. The manager has since informed the CQC about incidents as required.

The provider had allocated additional training resources to support the new manager with their training development plan. This included a visiting trainer allocated to attend twice each week for as long as was needed.

Prior to the inspection visiting professionals had expressed concern about the management of the home and care provided. We saw that the manager was making efforts to develop and improve working relationships. Professionals we spoke with following the inspection said they felt the manager had made a difference and they had noted improvement.

We reviewed a range of different policies and procedures which were in place at the time of the inspection.

All policies viewed were up to date and contained relevant guidance and information. Staff were also familiar with different policies discussed with them such as infection prevention and control, confidentiality, safeguarding and whistleblowing.

The registered provider had an up to date business continuity plan in place. This is a plan which has been devised to help ensure that processes are in place in the event of an emergency situation. The plan contained information and guidance which could be followed if the event of different emergency situations.



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
Diagnostic and screening procedures	The registered provider had not done all that was reasonably practicable to mitigate risks. The registered provider had not ensured the proper and safe use of medicines.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The registered provider had not ensures that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of regulated activities including the quality of the experience of service users in receiving those services.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	The registered provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the needs of the people living at the home.
Treatment of disease, disorder or injury	